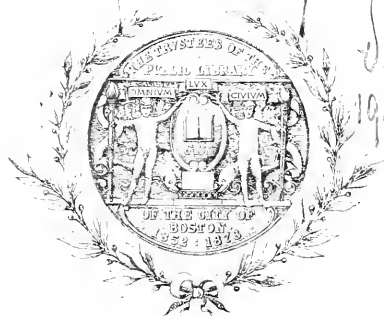


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Volume 11

July 1946-June 1947

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Children's Bureau

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THE
CHILD

JULY 1945

EUROPE'S DISPLACED CHILDREN

" - - Send these, the homeless, tempest-tossed to me - - - "



WE GAIN NEW CANDIDATES FOR CITIZENSHIP

CORNELIA GOODHUE *Division of Reports*

IN MAY 1946, 12 months after the close of hostilities in Europe, the *S. S. Marine Flasher* docked in New York with 795 immigrants aboard. This was the first time aliens had reached the United States by the usual channels since transatlantic shipping, the consular services, and international communications in general, had been disrupted by the war.

These people had experienced persecution unknown in Europe for several hundred years, but in other respects they were like their predecessors who came to America in the 1920's. They were not driven from their countries; they were not fleeing from sudden catastrophe. They had come because this was the country they wanted to live in. They entered under quota visas, planning to remain here and become part of America. There were old men and women coming to live with children and grandchildren. There were unattached young people. There were families with small children. The problems they will meet will be the problems their predecessors have met, generation after generation.

But among them were 67 unaccompanied minors whose problems are new in immigration and in child-welfare work. These boys and girls were orphans, as far as they or anyone else knew; they were below the age at which they could legally be responsible for themselves; and they were not coming to relatives or other interested individ-

uals who would be responsible for them. They entered this country under a corporate affidavit of the United States Committee for the Care of European Children. The Committee guarantees that the children will not become public charges and that they will be under the supervision of operating agencies approved by the Children's Bureau.

During the war years the United States Committee brought children to this country under a similar arrangement. But those coming now are older than the refugee child of 1940-45. Most of them are full-grown adolescents, beyond the age which fits easily into foster homes or at which children are usually adopted. Moreover, these are children from the concentration camps; they have had experiences which few people in this country know how to evaluate. They have lived for years without family ties; they survived, by ways of their own, where their elders did not; they were surrounded by persecution and brutality, and made their own terms with it.

Estimates as to how many such children would come to the United States varied from a few hundred to several

thousand. Opinions as to their mental attitudes and the problems they would present varied as widely. How had these children survived? Were they more hardened than their persecutors? Were they extremely cunning? Or extremely docile? Would they be listless and intimidated? Or over-regimented automatons? Or gangsters? Whatever outward form it might take, it was generally supposed that children who had not known a parent's protection, who had known only the slave driver, would not take kindly to authority. It was also expected that they would lie and steal since they could hardly have survived otherwise.

Not knowing how many children would come or what their real problems would be—knowing only that the children would be older adolescents, that they would be mostly Jewish, mostly Polish, and that there would be more boys than girls—the Committee got ready to receive them. A reception center was organized—a good kitchen and dining room; a play room with books, piano, and tables for games; and dormitories with three beds to a room. They planned to bring the new arrivals here, give them a thorough examination, outfit them in American clothes, introduce them to American ways, and learn something about them. After this each child would be sent to whichever affiliated organization seemed best able to meet his particular needs.

It is an accepted principle that chil-

Our thanks go to M. Ingeborg Olsen, Acting Director of the U. S. Committee for the Care of European Children, Lotte Marcuse, Director of Placement of the European Jewish Children's Aid, and Hilda Meyerowitz, Director of Case Work for the U. S. Committee's reception center, for their assistance in gathering background information for this article.—Ed.

dren need homes; that the less they have had of home life, the greater their need for it. But the age of these children, coupled with the type of problem they were likely to present, argued against foster-home placement. A number of well-staffed, well-equipped institutions for homeless children had offered their facilities to the Committee. To send the children to these institutions, in small groups, seemed the most promising solution. If this proved unworkable, there was the possibility of special hostels where they could be given exactly the conditions they needed. Whatever solution might prove best in the long run, it was felt that most of them should have group care in American institutions, for a while at least, if only to give American workers time to become acquainted with them. Because these children, whatever their problems might prove to be, would not be like the children our child-placing agencies are accustomed to dealing with.

Before the ship reached America the bare facts about the first group had been learned by cable—their age, sex, nationality, and religion. There were 67 boys and girls, 10 of them infants or preschool-aged. These were separated from the others at the dock in New York and taken temporarily to an orphanage equipped to care for young children. After a short period of observation they will be sent to child-placing agencies where they will be handled like other children of the same ages. It is not expected that they will present any special problems due to their backgrounds. The remaining 57, 51 of whom were 14 years or older, were taken to the reception center as planned.

A few days later the center was in full swing, boys and girls passing freely in and out of the building, finding their way to the corner drug store, mingling with the children of the neighborhood. At 11 o'clock in the morning the upstairs dormitories were empty. The beds might not have passed Army inspection but they had all been made up with an attempt at neatness. At the head of each bed was a chair or stool which served as a dresser. On these were treasures of all kinds—photographs, books, trinkets, and on one some loose change. Girls' bags were scattered here and there. Apparently no one ex-



Three candidates for citizenship, for whom social agencies will find homes, wonder what is ahead.

pected to be robbed. In the laundry a freckle-faced, 14-year-old boy was pressing the jacket of his suit. He was having a grim struggle, but smiled politely when he saw strangers watching him.

About 20 boys were in the game room playing billiards, ping-pong, and checkers. One was reading, and one was writing a letter. At the far end of the room a boy was playing the piano for half a dozen girls who were dancing. They looked like any lot of high-school boys and girls. There was not quite as much noise as 20 American adolescents might make; their voices did not actually drown the piano. And they ignored the strangers that came into the room, much as a group of adults would ignore strangers in a hotel lobby. But they were fine, healthy-looking young people. They were laughing and talk-

ing, obviously intent on the thing they were doing at the moment, not brooding on the past or the future. One could have found a more harassed-looking group of the same age on almost any street corner in the neighborhood.

That was in the play room. The medical reports, on file in the office, did not bear out the impression of robust good health. The children were all physically below par and in need of careful building up. In the office were also the UNRRA reports, and these too belied the appearances. It was hard to believe that those records—compact tales of horror on horror—could have any connection with the dancing, laughing children in the room beyond. It was impossible to believe that anyone could live through the things recorded there and ever laugh again.

These children were now 14 to 18

years' old. Six years ago, when they were 8 to 12, they were taken from middle-class, self-respecting homes and herded into ghettos where they lived like animals, too congested to keep clean, without privacy or comfort of any kind. The children remember little of their real homes. But while they lived in the ghettos, their ragged, unkempt mothers told them how things had been before. Their father, who now did nothing at all or worked all day with a shovel, had been an expert shoemaker, or a merchant, or a professor. They had had a home with beautiful things in it. They intended to give their children a good education. The children remember these tales; they remember particularly the education they were to have had.

After 2 years of this, when the children were 10 to 14 years old, the ghettos were emptied and they were taken to concentration camps. Families were broken up. Men who resisted this were

shot. It was soon common knowledge that the women and small children were being sent to the gas chambers, that only the able-bodied were being allowed to live. Many of these boys have seen their fathers shot, their mothers and little sisters loaded into the trucks whose destination they knew. Some of them slipped through the fingers of the guards at this time. They lived in the woods and fields of a hostile country, begging and stealing, trusting no one, always drawn to the centers where their own people were. One boy, after living for a year in this way, went back to his old home, hoping against reason that some other member of his family might be doing the same thing. The people who then had the house had been old neighbors; they recognized him and reported him, and he was caught and brought into camp. Another boy lived for more than 2 years in this way, but hovering near one camp after another.

He would get a few words with the men going out to work; each time they told him that children were put to death in that camp. At last death seemed less terrible than loneliness and he gave himself up. Other children lied about their ages, said they were older than they were and joined the work brigades. One girl of 10 said she was 12 and escaped with her life. Her 11-year-old sister, equally conscious of what she was doing, chose to remain and die with the mother. In America children of these ages frequently have their movies and radio programs selected for them; they are considered too young for the ugliness of life.

These children from the concentration camps are not ordinary children, on many counts. They have lived through extraordinary things, and extraordinary character was required to live through them. Again and again, the record says, "the only survivor of 200," "one of two survivors of 300." They have met and handled successfully situations which the adults who are trying to help them cannot conceive of, and perhaps could not have handled. They have done this without help or advice from anyone. Self-reliance is deeply ingrained in them and they will not lay it aside lightly; in fact, until they know whom they can trust, they will trust only themselves.

Their self-reliance is their most conspicuous characteristic. It is in their postures, in the proud, confident expression of their faces. It accounts in large measure for the fine impression they make as a group. It is so firm, so all-pervading, that it is hard to realize how much of it is pure determination to live, how little it is based on any notion of security. Occasionally something occurs which gives the outsider a glimpse into the inner life of these children.

The day after they were brought to the reception center they were told to get ready for some inoculations. There was a noticeable nervousness and tension about them while they waited for the doctor. The workers supposed they were afraid of the needle and said the appropriate things. Finally one of the younger children began to cry. Through her sobs the horrified attendants learned what all the children were thinking—the little babies, who had

Some of the unaccompanied children coming to the USA will find homes with friends or relatives.



been separated from them at the pier, were already gassed; now the rest of them were being tested for something they could not understand. The adult Americans were almost unnerved by the story. But these children had carried themselves proudly, had behaved reasonably and courteously, while threading their way through a world in which such things are to be expected.

It is this amazing courage and endurance which makes these children unlike the usual American child. One of the boys at the center had some scraps of paper on which were the names and addresses of people he did not know, given to him by people he scarcely knew. He treasured these because he had no friends in America and supposed he would have to make his own way after he got here. Distant relatives or friends were found for some of the children and these came for them a few days after they arrived. When that happened the others became restless and uneasy. They supposed the time was coming when they must all go their own ways, and were very uncertain how to set about it. When they were told that was not necessary, that they would be cared for as long as they needed care, they were relieved but they did not stop making their own plans.

During the first week the children were at the center, they were very reluctant to let anyone plan for them. They questioned every step taken and frequently insisted on verifying what the worker had told them. Then, almost in one day, a change came over the entire group. Suddenly, they were all asking for advice. Plans had been completed for half-a-dozen of them, who had therefore gone on to their new homes. These had all written back to the other children, and they had all told the same story—they had found everything just as they had been told it would be! This seemed to be all that was needed to dispell everyone's distrust. One boy who had been hesitating between two possible placements and who had been assured that the decision would rest entirely with him, came to the case worker and said, "I wish you would decide this for me, you know so much more about Americans than I do."

Even when they are most distrustful, their independence does not carry with it the difficulties usually associated with



Few such young children are among the groups being brought to this country by the U. S. Committee.

"waywardness." These children are mature in other ways, too; they are intelligent, reasonable, and considerate. All who have come in contact with them report the same thing: "they evaluate people and situations well," "they have unusually good judgment," "the children's judgment is excellent," "they have an amazing sense of values," and "amazing integrity."

In one instance a boy of 17 objected very much to remaining at the center at all. He wanted to be on his own. Even if the worker had been convinced that he was able to take care of himself without any help, she was not free to let him go as long as the United States Committee was legally responsible for him. His record showed that he had escaped from half a dozen concentration camps. She mentioned this to him and said, "If you want to get away from us, we won't be able to prevent you. But if you do that, we will be in trouble and may have a hard time bringing any other children from

Europe." That was sufficient for him. He did not want to injure them or the others who would be coming after him. He was willing to conform for their sakes, where he would not have submitted to what seemed an unreasonable restraint.

While they are at the reception center, the children are given as much liberty as possible—that is, the same liberty that would be given to adults who were part of a community life. This includes, among other things, complete freedom of choice in religious matters. Here the children's wishes are accepted without protest. It often happens that they change their minds after a few days, sometimes for profound reasons and sometimes for trivial ones. This also is accepted. A few of the boys said they had no interest in religion. One who had asked for a Jewish prayer book changed his mind by the time it arrived and did not take it. On the other hand, a girl who called herself Polish Catholic was fascinated by the Jewish kitchen.

She hovered around the door for a couple of days, and finally told them that her people were Jewish. When the Germans first came into Poland, Catholic neighbors had taken the child; they had forged papers for her and taught her prayers. That was 6 years ago. She had gone with this family to a German work camp. From there she had come into an American camp for displaced persons. She believed that her Christian status had helped her a great deal and she had intended to keep it, until the memory of her mother's kitchen proved too much for her.

There are certain people in America who would not approve of such liberty, or license, being given to children. But these young people are not children. And this liberty is the most precious gift America can give them. Nothing will ever show them what we mean by liberty and equality as clearly as this experience of classifying themselves, and reclassifying themselves again and again if need be, without any change occurring in anything that is done for them. Will foster parents be as respectful of their rights and liberties?

The United States Committee for the Care of European Children does not place children in foster homes. Children brought to this country under its auspices are placed with established local agencies who in turn are responsible for seeing that they get the particular care they need. The number of such children expected to enter the United States is small, due to immigration restrictions, and the number of agencies receiving them for care will therefore be limited. Many more families can be expected to seek a child for adoption than there will be children available. Families eager to adopt one of these children are urged *not* to direct their inquiries to the U. S. Committee, but to get in touch with their council of social agencies which will know which local agency is in charge of any European child needing a home.

The 57 adolescents who came on the *Marine Flasher* all asked to be put in families. They were lonely children and wanted to have people who belonged to them and who loved them and were interested in what happened to them. Some of them said specifically that they wanted to be in families where there were no other children, that they did not think they could bear it if there were other children who belonged more truly than they did. They disliked being in groups of their own age. At the center they objected to being taken downtown in groups of six; they said it looked silly.

Homes will undoubtedly be found for most of these. Other groups coming in may require different handling but some will go into American homes. Where that happens the foster parents should be prepared for the special problems they are likely to meet. These children are in no sense "delinquents." They are pathetically grateful for affection and return it warmly, and they will accept guidance and advice, but only when they are sure they can trust the person giving it. The foster parents must expect a period in which they themselves are on probation and the child examines them. They must be patient and reasonable, willing to explain their own positions and to listen to criticism. The adult must recognize the child's maturity; he can be guided but he cannot be overridden. Once the child learns that he can trust the adult, few difficulties of any kind are likely to arise.

If such homes can be found, other problems may be expected to solve themselves. The homes are the great need. But that is not the way the children see it. They put the homes second. The thing they put first, and for which they will sacrifice everything else, is *their education*.

Again and again the UNRRA records show that the child came to the United States because he believed he could get the best education here. Many of them actually came into the American zone of occupation, from other areas, for that reason. If anyone attempts to argue with them, to suggest that they might be happier earning than learning, they grow desperate. They claim that they have been deprived of their childhood and that the only way in which this can

be made good to them is by allowing them to go to school now.

The U. S. Committee had supposed that during the first days the children were at the center, their time would be sufficiently occupied with the physical examinations, the outfitting in clothes, the games, and short trips around New York. Lessons would be provided later. But these boys and girls were so intent on getting their education that they considered any other activity a waste of time. One girl, wandering restlessly in the hall, told the recreation worker—"we have been here 2 days and classes haven't started yet." That has now been changed. When the next group arrives, they will have classes in something the first day.

These children may be looking forward to training as a draftsman, or a mechanic, or a nurse, but doubtless the great majority want academic education. One 16-year-old girl, who has had no schooling since she was 10, is determined to become a doctor. She has intended to become a doctor since she lived with her mother in the ghetto 6 years ago, and she will not be put off by any talk of what is hard and what is easy and something else that is just as good.

It will cost something to give these children an education; if they are able to go as far as they think, it may be very expensive. There is also a question as to how much education you can give an 18-year-old beginner. But the answer to this is not obvious; it is something that will have to be found out, and the problem should be of interest to teachers. Such a beginner, obviously, does not fit into our established school system, and special arrangements will have to be made, for a while at least. But these problems are not insuperable ones.

If the children are able to go through school, they should be helped to do so; and whether they are able or not, they should be allowed to try. There will be some, of course, who will not be able to go on, but they should be allowed to continue school until they themselves recognize this and want to stop.

The problems discussed here are those presented by the 57 adolescents who made up the first group. Before these boys and girls had been at the reception

center a week a second group arrived—18 Estonian Protestant boys. Superficially, the two groups were different in every way. These Estonian boys had been orphaned and driven from their country by war; they had lived for years in the German labor camps. What they had endured was bad enough, surely, but it was not to be compared with the sufferings of the Polish Jews. These two groups had had very different war experiences; they were of different racial stocks, with different physiques, and different ideals. The Estonian boys wanted simply to be farmers. The Jewish children had put great importance on kinship; they valued a family tie however distant. To these Estonians a blood relation meant very little; a stranger was a stranger. What the next group will be like will be known when they get here.

But the differences are unimportant. The real problems for both groups, and for all the young victims of the war who may follow them, are the same. They are all lonely children with the courage and independence of adults. They all need, above everything else, love and affection from adults who will treat them as adults, as grown children. And they are all very proud.

One must never forget their pride. The worse the degradation they have known, the prouder they are. This is not a paradox, or a brave defense; it is the inevitable effect of what they have been through. Comfortable people are proud of their comforts but no pride in material things, or in success of any kind, can equal the pride that comes of being reviled and persecuted for righteousness' sake. Those families, herded like animals for slaughter, did not think

they were the unfortunate of the earth; in their own eyes they were martyrs and died in glory.

The most self-conscious tradition in America is rooted in a similar pride. The French Huguenot, the English Puritan, the Scotch Covenantor, all gloried in the fate that had been wreaked on them. Their children sanctified them, applying to them the proud words of St. Paul:

They were stoned, they were sawn asunder, were tempted, were slain with the sword; they wandered about in sheepskins and goatskins, being destitute, afflicted, tormented; of whom, the world was not worthy.

We must remember that our newest immigrants are in this American tradition.

Boys from Buchenwald look very different when they reach America, are dressed in American clothes, and their faces brighten with faith in the future





THE UNITED STATES HAS HELPED BEFORE

RUTH CRAWFORD, *Division of Reports*

SINCE JANUARY 1933, several thousand unaccompanied European children have been brought to this country by relief organizations, principally the European Jewish Children's Aid and the United States Committee for the Care of European Children. Various other organizations, among them the American Friends Service Committee, the Unitarian Service Committee, and the Na-

tional Catholic Welfare Council, have likewise had a part in the undertaking. All told, though, considering the desperate plight of so many, the number that have come is surprisingly small.

The European Jewish Children's Aid, despite all its efforts and the great urgency of its mission, succeeded in bringing in fewer than 600 children from 1934 to 1943. The U. S. Committee which in 1940 was expecting to bring over

thousands—32,000 British children were once reported registered for evacuation to this country—actually brought less than 1,500. In the fall of that year, the *City of Benares*, carrying British children to Canada, was sunk by a submarine, and after that tragedy, the British Government refused permission for any others to leave.

That the number of children brought in was small does not mean that the need was not as great as anticipated. The effort made is to be measured not by numbers rescued but against the difficulties encountered.

Who were these children who came to America?

The largest single group was the British evacuees. Most of the others who came were Jews—Jews from Germany, Austria, and then the other countries of Europe in the order in which they were overrun by the Nazis. All these children were separated from their parents and many were orphans.

Besides these two main groups—the British evacuees and the Jewish refugees—there was a third. Some 40 Spanish Republican children came from the internment camps in southern France. Others who came were less easy to account for, but all were children "picked up" by American relief organizations on the Continent, and all were children who were sent here only after a most careful consideration of their problem.

The American Friends Service Committee was among the first to act on behalf of these refugee children. So was the National Council of Jewish Women, and out of its efforts to find a way of expediting emigration grew the German Jewish Children's Aid, later the European Jewish Children's Aid. Since 1934, this organization has been the agency through which other Jewish organizations have worked on behalf of these orphaned and homeless Jewish children.

Then, in 1940, in anticipation of the evacuation of British children and possibly still some others from the Continent, the United States Committee for Care of European Children was formed as the over-all agency through which the efforts of many groups could be coordinated. It continues to function in that relationship.

Practical problems that would have

discouraged those less convinced of the importance of what they were doing beset these organizations at every turn. Not the least troublesome matter was obtaining permission for the children to enter. Ordinarily an individual affidavit, a pledge of responsibility by someone in this country for a particular person, has to be obtained and then approved by the proper United States consul abroad. Such individual sponsorship soon was out of the question. In the first place there was no time to get a visa. Secondly, most of these children had no relatives here, or at least none in a position to bring them here. Moreover, who was to come and how and when could not always be determined until immediately before the ship was to sail.

The European Jewish Children's Aid, until 1940, managed to work within the usual immigration procedure, but obviously, if any considerable number of children were to be brought over, the procedure had to be modified in order to get the children out while there was still time. It was, drastically. On July 13, 1940, the Departments of State and Justice, after conferences with the Children's Bureau and the U. S. Committee, jointly approved a revised migration procedure for children seeking to enter the United States.

Instead of an individual affidavit for each child, a corporate affidavit procedure was agreed on. Under this rule, the U. S. Committee made itself financially responsible for a group of children, guaranteeing that none would become public charges. Another requirement under the corporate affidavit was of great importance. To make certain the children would have good care, the organization bringing the children was required to work with children's agencies in placing the newcomers in foster homes that met standards set by Children's Bureau.

Thus a measure of public responsibility was accepted for the incoming children.

The corporate affidavit of the U. S. Committee, by cooperative arrangement, is now being used for both Jewish and non-Jewish groups, and the Committee has legal responsibility for them. However, while the children are at the reception center, each group assumes responsibility for the care of its

own children. The European Jewish Children's Committee takes the Jewish children under its wing, and the Committee on Refugees of the National Catholic Welfare Conference does the same for the Catholic children. Aside from the British children, very few Protestant children have come. At the present time the U. S. Committee itself exercises full responsibility for them.

Prior to the children's coming, each organization, of course, had to be certain that suitable homes would be available. This could be done only on a tentative basis, since usually all that was known about the youngsters in advance was their nationality or religion, their age, and family grouping. Through local welfare agencies prospective homes were found and reported to the sponsoring group.

Final plans for allocating the children to cooperating local agencies were not made, though, until after the national organization had a chance to become acquainted with them and knew something of their individual needs. To provide such an opportunity, the children, on arrival, spent some time in

reception centers in New York City. The only exception was in the case of some of the British children for whom plans had been made before their departure. Yale professors, for instance, took children of Oxford dons; an actors' group took actors' children; employees of firms with branches in Great Britain took in children of British personnel.

Where the children were to go depended upon many factors. If there were relatives, the possibility of placing the children with them was explored, or, the agencies tried to place them in homes near relatives or family friends. An effort was always made to keep children of a family together, in the same foster home or in the same community. Language also had to be considered. And, as in all child placements, the type of home available had to be weighed in terms of the individual child's needs.

No less than 113 local agencies in 33 States were involved in the placement and supervision of the British children brought in by the U. S. Committee. The children for whom the European Jewish Children's Aid was responsible were at

Millions have known no other life than one filled with suffering, starvation, and disease.—H. H. Lehman.



one time under the supervision of agencies in 45 cities, in 27 States and the District of Columbia. The Spanish children were widely scattered, some of them going to Spanish-speaking families in Texas. Reports on all these children were sent to the national office, and through a field staff, close track was kept of them.

Placing these children required the highest skills of child-welfare workers. They had to work in the dark, or near dark, on many matters that are of prime importance in a successful foster-family relation. The child-welfare workers often knew little or nothing of the child's family, its customs, its traditions. Then, too, the experiences that many of these young people had been through—experiences far removed from those of both the child-welfare workers and the foster parents—made understanding even more difficult. Still another complicating factor was the age of the children. Most were young adolescents, a group never easy to fit into a foster-home situation.

Each group that came brought its own special problem. The British children

made their adjustments more easily perhaps than the others, for there was less difference in culture.

All of these children, though, the British included, were living through one of the most harrowing of all childhood experiences—separation from their parents. The British had the advantage of knowing they would be reunited later. The others could no more than half believe that they would ever again be with those they loved. Sometimes their parents tried to prepare them for that separation. "You are a child in years, but you are not a child," they had said. "You, and only you, have a chance to save us all." The parents may not have believed a word of their injunction, but they knew that the separation would be easier if it had a high purpose. Many times, though, only uncertainty surrounded the child's departure, the fate of the parents being unknown or else too well known.

Many of these children—the British again were an exception—had been uprooted not once or twice, but many times. They had become wary of counting too much on anyone or on any home.

They had seen people die; they had seen people killed. They had lived through bombings, many of them, and some had memories of machine-gun strafings. They knew what it was to live with people huddled together in uncertainty. They had seen human beings at their best, if fortitude is the measure; they had also seen them at their worst.

They had, in other words, lived a lifetime in a few years and now they were starting life anew in America.

Waiting for them here were an expectant lot of foster parents, all people whose intent was high, but people ill-prepared for what was ahead of them, for little in their own experience matched that of the children they were taking into their homes. Some of these foster parents were relatives—uncles, aunts, cousins—but they were little better acquainted than the others.

Both the children and those who made homes for them found themselves in a situation far out of line from that anticipated. Each would have been surprised—and shocked—at what the other expected of the relationship.

The foster parents saw themselves in the role of benefactor, the recipients of the love and gratitude of their young charges. Gratitude, though, is something youth has little of; that comes later. Love was not always forthcoming, either, though often strong emotional ties did develop. What happened was the only thing that could have happened; these children took the measure of their foster parents not as benefactors but as human beings and gave or withheld respect and affection on that evaluation.

The idyllic picture was frequently twisted awry.

There was, for instance, the problem of over-placement or under-placement. The hazards of placing a child in an environment socially far above that of his own home, particularly when his stay there was to be only temporary, were not to be overlooked, yet often there was no alternative. Only people in the middle or upper income brackets could undertake the responsibility, particularly when care might be required over a period of years.

Aside from the fact that these were not necessarily "the best homes" in terms of the child's need, there was the all-important consideration of the

Praised for stealing from the enemy, these children now have to learn that it isn't smart to steal.



child's own happiness. A child can be miserable in an environment in which his speech is different, his table manners or lack of them set him apart, the family's interests are not those of his family, and so forth; and an unhappy child is not an easy child to live with, as some of these well-to-do foster parents realized. The danger was, of course, just as great the other way around, that is, in placing a child with advantages less than those to which he had been accustomed.

Foster parents winced and in time were angered by the children's comparison of what they had had in Europe and what their new home offered. Sometimes only youthful candor was behind the remark. Sometimes it was just plain homesickness, and sometimes it was intense personal loyalty—an attitude frequently met, for building up their own families was the children's only way of assuaging their loneliness.

Loyalties these children brought with them, loyalties often undivined by their foster families, were at the base of much of the adjustment difficulty. Those who still had family ties were in conflict between their growing attachment to their new family and their sense of what was due the old. Loyalty on religious and political grounds had to be understood. These were children of women and men who had suffered greatly for their faith and their conviction, and their children were steadfast.

Besides these difficulties that had their origin in the extraordinary circumstances of these children, there were those conflicts of personalities that would have been encountered in any placement of a similar number of children. There was, too, the problem of relatives. A sense of duty impelled many to offer their homes, though they were not financially able to do so, nor were they temperamentally suited. When others took the children, the relatives sometimes interfered, and their influence was often resented by the foster parents as well as by the children.

Placement agencies also had to guard against those who would exploit the children. Some thought to get a "good strong girl" who could help with the housework or the younger children, and some wanted a boy for the shop, store, or farm. One woman, it developed,



Behind the rubble and rags, there's still a home of sorts for this child which is more than many have.

wanted a companion for her feeble-minded daughter.

Temperamental unsuitability of some of the foster parents also presented problems. They liked the idea, but they were often irked with the actuality. Some had forgotten what having a young person around was like, though they had had families of their own. Some wanted a boy or girl in the image of one they had lost. Then, too, there were those who saw the child as a refugee, and continually put him forward in that role, though it became wearisome and irritating to all except the foster parents.

Thus the venture in which the deep sympathy and high hopes of so many were engaged on both sides of the Atlantic turned out to be very human indeed. In most of the placements, in by far the most, though, the difficulties were met and overcome and the boy or girl was soon taking his place with other children in the family, the school, the church or synagogue, and the community generally. In many, many instances permanent ties, as close as in any family, were developed. Yet, there were those other cases in which foster parents wanted to be relieved of their responsibility; relatives complained; and children were unhappy.

Then, the importance of that provision in the corporate affidavit that required supervision of a child-placing agency was fully appreciated. The child-welfare workers stepped into the situation. Often all that was needed was an interpretation of the boy's or girl's behavior or sometimes it was the foster parents' reaction that needed explaining to the young person. Sometimes, though, the foster-home situation was impossible, and other arrangements were made.

In still other ways, supervision stood the children and the families in good stead. Unforeseen expenses, for instance, were borne by the central organization. One of the boys, in an accident, became paralyzed. The expensive care and treatment required over a long period were provided from U. S. Committee funds. A change in a foster-family situation—a move to another community, a divorce, or the foster father's going into the service—sometimes necessitated new plans. For some children boarding-home care had

to be arranged; sometimes institutional care was needed, and when this was true the organization's limited funds had to be drawn upon.

Then, too, there were legal matters. Some wanted to adopt the children, and in some cases, adoption seemed desirable on all counts. However, the rights of the natural parents and others of the children's own family had to be protected even though their whereabouts, if they were living, were unknown. Questions of legal guardianship arose, as for instance, when consent was required for an operation, or for a marriage, or for a 17-year-old entering armed service. In these, and other matters, the agencies and the central organizations participated.

The experience, in terms of social work, has been enlightening to both the foster parents and the agencies.

These foster families were of an economic and social group whose only experience with agencies, if they had had any at all, was as board members. For most social work lacked any reality: it was something for people "on relief," for people unable to manage their own affairs. Yet here they were, dealing with social workers on their own problems.

The agencies, too, were enlarging their experience. They had to learn how to use "free homes," for one thing, and how to work closely with a group often quite different in attitude from those with whom they were accustomed to deal. They had a unique opportunity, however, to interpret the work of a social agency and particularly a child-welfare worker, to an influential group, and out of this effort made on behalf of refugee children, it is hoped may come wider community support for children's services generally.

Meanwhile, what of the children themselves for whom the effort was made?

They have had the protection their people would want them to have, and that is saying a good deal in the case of many whose hope for a future was once so slight.

The British children have now gone home. Some of the others have been reunited with their parents or relatives in other countries, and in some instances, their relatives have managed to get here. Those remaining here are well on their

way to becoming full-fledged American citizens. At 18 they can apply for citizenship.

Some have already attained that status, and they are acquitting themselves creditably in their adopted country. The oldest are only in their late twenties, a fact to be kept in mind in considering the record they are making.

At least five are now instructors in American universities. One, at the age of 20, testified before a Senate committee as an expert on agricultural economics. The scholastic record of others is likewise high. Almost without exception they are intent upon getting an education.

Many of the boys, now young men, served or are serving in the armed forces. One at 24—"a little brat when he came"—was an Army captain in the U. S. Army. Some, ironically enough, are with the Army of Occupation in Germany.

The girls, like the boys, are doing what might be expected of their age group. Some are going to school. Some are teaching or working in offices. Some are WAVES and some are WACS. Some are caring now for homes of their own.

A considerable number of both boys and girls are self-supporting, or practically so. Some, with their savings, have brought their parents or their brothers and sisters to this country, and others are contributing to the support here of younger relatives.

Now, other boys and girls are coming, and it can be expected that many, many homes will be offered to them for these European children have a special appeal. In some ways finding the right homes or the right place for these newest comers will be the most challenging of all similar endeavors: the boys and girls who are coming now have had far more maturing experiences than those who preceded them.

Fortunately, there are those on hand to welcome them who have learned, these last 10 years, something of what is involved in finding and making a home for these young emigres. Their experience can now be drawn upon to insure the success of the venture not only as far as the foster parents are concerned, but above all, in terms of the security and well-being of these newest candidates for American citizenship.

HELPING CHILDREN TO A NEW START

CURT BONDY

SELDOM BEFORE have we faced such a peculiar and interesting task of education and reeducation as now in caring for the orphaned children of Europe who are coming to our shores.

Particularly is this true of the teenage youngsters. During their tender years these boys and girls have led a life few adults here have ever experienced. They know privations, horrors, tortures, and death, in concentration and labor camps. They have made the fight for survival in uglier forms than most soldiers have. They have labored as only few men usually have to do. They are independent and grown up though they have many immature traits. They know little or no family life and have had not much regular education. They have lacked many of the influences

Dr. Bondy's thoughtful cautions on the psychological needs of children who will come to live in this country grow out of his own extended experience and his contact with workers in Europe who are caring for refugee children. His work with such young people began in 1936 when he was director of an agricultural training farm in Germany. Later on he was active in refugee work in England, Holland, and Belgium. He knows the refugees from concentration camps from his own experience as an inmate in Buchenwald. Before 1933, Dr. Bondy was professor of social psychology and social pedagogies at the Universities of Hamburg and Goettingen. At present, he is associate professor and head of the Department of Psychology at the Richmond Professional Institute of the College of William and Mary, Richmond, Va.

which normally form the character of a child.

On the other side, these children have known mutual help, sacrifices for their friends, courage, generosity, and unselfishness such as only soldiers in the front-lines may have experienced.

When they are distrustful and shy, they may long for love and understanding. When they are excitable and unstable, they may yearn to settle down. They may have difficulty in concentrating, and at the same time, be extremely eager to study and learn.

It takes skill in planning the future with boys like these three teen-agers who still have many immature traits though they are independent and grown up.



For the care of these youngsters we should use only the highest type of worker. They should also be able to talk and understand the children's language. Young workers should be secured as group and recreational leaders. From other experience we know that often group leaders who are only a few years older have an especially strong influence on their charges. All available knowledge and methods of case work and group work should be applied.

If properly done and evaluated, the work with the first groups can furnish us with a great deal of valuable material and new experiences which can be used for future groups, and in other fields of reeducation in this country as well as in Europe.

England has already taken in many children from the Continent. Their backgrounds are similar to those of the children coming here. Some days ago I received a letter from a friend who is working with a group of these children placed in a hostel there. Herself an

inmate of a concentration camp on the Continent, she had worked there with children and accompanied the first group which went to England. One of the few difficulties with the children now, she writes, is that generally they feel that after all they have suffered the world owes them a living and that they have an unquestioned right to assistance and support. They know nothing of how difficult it is for most people to earn a living in peaceful pursuits.

Whatever we do for the children who come here, we should not expect gratitude. They will be antagonized by any effort to impress on them how much we are doing for them. To be thankful is something that few adults can achieve even under normal circumstances. Therefore, we should not expect gratitude from youngsters whose lives were and are already so difficult.

These children may present a paradox: they may resent charity and yet not want to stand on their own feet. We have encountered such an attitude

from time to time in people who have endured hardship and privations in internment camps, who have not been able to care for themselves, and who have suffered for years at a time. The social worker in this country knows similar attitudes in people who have been unemployed for a long time.

All of these peculiarities should be kept in mind in dealing with these youngsters. They should not be transferred into foster homes or the homes of relatives too soon. For in many cases, families may have difficulty in understanding or tolerating such an attitude.

According to my friend in England, the older children themselves are of the opinion that they should not be placed in families. They want to complete their education and then get a job so that they can make their own living. All who were placed in the families of relatives, with but one exception, returned to the hostel.

Another point reported to me is an attitude which may be difficult to un-

Bodies and spirits must be rebuilt from devastated homes like this one.



Group loyalties must be respected in planning a new life for youngsters like these, encamped in North Africa.



derstand in this country. It is the "white collar" complex of the children; they have a very low opinion of manual work. Partly this can be explained because they have been forced to do slave labor.

On the other hand, they have an exalted regard for intellectual work. This may help to explain their strong desire to study and learn. Up to now, their education has been very irregular, and in many instances, they have had no formal schooling at all. Appearance—and especially clothing—is also given a value out of all proportion to its real importance.

Only a small percent of the young people in the English hostels have been found to be wayward, none of them delinquent, and only a very few mentally disturbed. During the first weeks in their new home, some were unable to sleep properly, but this soon disappeared. Bed wetting is even less frequent than in other institutions.

All of the children improved physi-

cally and mentally soon after reaching England. The change for the better could be noticed almost from hour to hour.

Here in the United States we can be helped by knowledge of the experiences with the children in other countries. But we will be wise if we keep tentative all plans for the children coming here until after they arrive and we know much more about them generally and as individuals.

The outcome of our educational efforts will be determined not only by the personality of the youngsters, but to a high degree by the people working with them, by the methods used, and, not of least importance, the "social atmosphere" in which the children are placed.

The question will arise whether gangs that have been formed should be disbanded. I am definitely against breaking up such a gang too early. These boys may have been together for a very long time, maybe the loyalty to their group and their leader is the only loy-

alty they have at the moment. One should try to convert such a gang into a social group.

Under no circumstances should the youngsters be forced to live in a system of barracks. They need to feel that at last they have found a home, their home, and that they are not in a camp any more. In a home-like setting, they will find it easier to quiet down and adjust to their new environment. We know how many of our returning servicemen need some weeks of peaceful life and security at home in order to lose their restlessness and find their way back to civilian life. How much more, then, will these youngsters be in need of rest and enough time to get used to completely new conditions.

Life in an institution—temporary or long-time—should be carefully planned beforehand. Though these children should have the most freedom possible, from the first day on, there should be a certain discipline and fixed order. If a change is advisable, it will be much

Proud of his Maquis record, this 13-year-old boy must relearn what peaceful living is like.



All these children, even the little 7-year-old at the far left, have behind them life in a Nazi camp.



simpler to relax rules than to tighten up them. My friend in England writes, "A law we keep foremost in mind and work hard never to violate is this: never make any promise which cannot be kept. That gives them confidence and security."

As soon as possible the cooperation of the boys and girls should be extensively utilized. Responsibilities and duties can be delegated to them from the very first. These should be increased gradually. The young people themselves should do most of the work and also enforce the necessary discipline and order. They should be convinced that every effort will be made to do what is best for them. English-language and discussion groups can fill one of their big needs—information. Their questions will be not only of a general but of a personal nature, too.

Although they may give an impression of being cynical and rough, fundamentally most of them are not. Behind such a front can well be a hunger for affection, love, and tenderness. These

youngsters will be filled with distrust and sometimes will be aggressive. They should be treated with true friendliness and genuine personal interest by the persons working with them. These young people are highly sensitive and will quickly realize if an attitude is only a matter of policy. They need sincere affection, love, and tenderness, even more than those who have led normal lives. They need these every bit as much as they need food, drink, and shelter.

Thus the youngsters coming to us will likely be very eager to form personal relationships. They may perhaps act very grown up and independent, while wanting and needing a person to whom they can give their confidence and affection. Too often they have been moved from one place to another, and personal relationships have been created and cut off again and again. Now they will probably show a great readiness to accept guidance and leadership, and strong personal ties will be easily formed. They will need lead-

ership of persons they can look up to. Though the feminine and motherly influence is important, especially the boys definitely need the leadership of men.

In the transplanting of these uprooted children, advantage should be taken of any cultural and religious affiliations, or of any interest in sports or hobbies they may have.

Any segregation should be prevented to the utmost. The more contacts the youngsters are able to make with other people, the better. This will help to prevent any feeling that they are still apart, that they do not yet belong. If they have relatives, and as they gain friends, they should be permitted to visit them as often as possible. Also, they should be given a chance to know different youth groups and to exchange visits with these groups.

Slowly, gradually, their lives will emerge out of the still lingering shadows. It will not be easy for them. It will not be easy for those who are working with them. But it could become a fascinating task and experience for both workers and youngsters.

Strong, these boys were able to survive Buchenwald. Now, the hardships suffered there must be repaired with the best kind of medical care.



REBUILDING LIFE FOR HOMELESS CHILDREN

European and American relief agencies give a hand to children of other nationalities

FRANCES BALGLEY, *Division of Reports*

ANYTHING DONE to rehabilitate a country helps its children. Rebuilding the land, industrial plants, roads, markets, and all the other physical things adults live by helps to rebuild life for children.

But children must have more than a physical basis for living. They need to feel they belong to someone who cares deeply what happens to them. War killed that feeling of belonging in countless numbers of children who lost parents and close relatives. A first task of peace is rebuilding a sense of security for these boys and girls by finding new homes and encouraging new relationships for them.

Each European country has its own way of tackling this task for its own waifs of war, and most of them are reaching out to other children who have been uprooted from their native lands and families. We have attempted to gather here reports of the help that is being offered these children by government and private welfare agencies of countries of which the children are not nationals, and by four representative private American relief organizations.

Services offered to displaced children by UNRRA have been excluded from this survey. Likewise excluded are reports of the care being given by wartorn countries to their own children who have been orphaned by the war.

Information about the help being offered displaced children by the governments of European countries and by welfare agencies was gathered mainly

from the official and unofficial representatives of those countries in the United States.

The four private relief organizations in the United States chosen to represent the many such groups in this country which are sending aid abroad are the American Friends Service Committee (AFSC); the Joint Distribution Committee (JDC); the National Catholic Welfare Council-War Relief Services (NCWC-WRS); and the Refugee Relief Trustees, Inc. (RRT), parent body of the American Christian Committee for Refugees, Inc., International Rescue and Relief Committee, Inc., and the Unitarian Service Committee.

In the main, these organizations have been sending aid overseas in the form of food, clothing, medical supplies, and other necessities. They have contributed toward the cost of transporting refugees, and of providing welfare, educational, and recreational facilities. All four organizations have representatives abroad to facilitate distribution.

Some have staffed children's homes, dispensaries, and guidance services with professional workers as well as providing them with supplies.

Whenever possible, these organizations operate in cooperation with and through the governments and relief organizations in the countries in which help is offered. For example, aid sent to France by the NCWC-WRS is given to that country through *Entr' Aide Francaise*, the semi-official coordinating welfare agency in France, which in turn allocates the supplies thus received to the Sisters of Charity of St. Vincent de Paul who dispense most of the Catholic charity in that country. Similarly, the JDC channels its aid to France through seven major Jewish welfare agencies; to Belgium through *Aide aux Israelites Victimes de la Guerre*; and to people in occupied Germany and Austria through UNRRA and Jewish relief organizations working in that area.

The AFSC attempts with its material help to stimulate the efforts of na-



tional or local public and private relief organizations so that when these groups can operate under their own power, the Committee can withdraw its support to lend it elsewhere.

This survey does not pretend to cover completely all activities now under way for Europe's children. Countries which are themselves recovering from the effects of the war and are in addition offering help to others are hard pressed to keep records of what they do.

Similarly, many more services for Europe's children than are mentioned here are made possible by the contributions of the people of the United States through numerous relief agencies not covered. The agencies included in this survey and the services they render are typical rather than all inclusive.

Few displaced children are known to be in Albania and Finland. No information was available, however, concerning these countries' efforts on behalf of children of other nationalities. Nor was information concerning Portugal or the Soviet Union's efforts for displaced children available in this country within the magazine deadline.

Belgium

From 1939 on children of many nationalities came to Belgium as refugees with their families. During the German occupation many of these children were hidden by Belgian families when the adults were deported to Germany. Several thousand children whose parents have not since returned were saved in this way. Many of these children have since found permanent refuge with relatives in Belgium, England, and other countries. Those who are left live in special children's homes which are supported and supervised by Oeuvre Nationale de l'Enfance (ONE), the official coordinating welfare agency in Belgium. ONE delegates operation of these homes to Aide aux Israelites Victimes de la Guerre, which is supported also by the JDC.

The JDC reports that 1,446 Jewish children and youths were being cared for by Aide aux Israelites Victimes de la Guerre in April 1946. Among the 14 nationalities represented, the 953 children from Poland made up the largest number. The total group included 796 orphans, 347 fatherless and 158 motherless children. About 575 of the

children were in children's homes. The others lived with foster families. Activities were in progress for the emigration of 270 children.

Belgian families have taken about 2,000 Dutch children from bombed cities into their homes for 3-month periods.

Bulgaria

From the fall of 1944 to the winter of 1945, about 12,000 Yugoslav children between the ages of 4 and 15 were guests of the Bulgarian Government. The children, most of whom were orphans, lived in schools converted into child-care institutions. Many of the children were sick and received medical care. Education was provided by Yugoslav teachers who accompanied the groups.

Three hundred Polish and one hundred Albanian children are recuperating in Bulgaria this summer as guests of the government.

The JDC reports that it is aiding 2,000 Jewish children in the country.

Czechoslovakia

Czechoslovakia, during the occupation, was forced to support 1,100,000 German mothers and children who were sent to that country to escape hostilities. Czech mothers were held responsible for the health and living conditions of their enemy "guests" who by decree received preferential rations. German children ate meat and fruit when Czech children had none.

During the occupation, large numbers of German children spent summer and winter vacations in children's homes in the Tatra Mountains. These children were evacuated back to Germany before the Russian Armies advanced into the area.

Czechoslovakia is now caring for 43,000 of her own war orphans in government supported orphanages. A few hundred German children are in this number. They will be kept in Czechoslovakia until some humane policy is formulated under which they can be returned to Germany.

The JDC helps support a children's home, a convalescent home, and a camp in Czechoslovakia, which together accommodate almost 700 children. This organization also financed, in cooperation with the Czech Government, a 3-month trip to Switzerland for almost



For health safety, Berlin children are moved to the country.

a hundred pretubercular children. The JDC furnishes general aid to a total of about 2,000 children.

Four orphanages in Carlsbad, which house some German children as well as Czech, are aided by the NCWC-WRS.

The RRT helps support a children's home in Olesovice.

Denmark

Denmark now supports 210,000 "intruded" Germans who were brought into the country toward the end of the war for protection. They are housed in about 200 camps and are fed, and given medical attention. Schools for the children and recreational facilities for adults are also provided. The health of this group has been greatly improved, although the rate of infant mortality is still higher than the rate for Danish infants.

All Danish relief work for foreign countries is coordinated by the Committee for Coordinating International Relief, an official body appointed by the Danish Government after liberation.

Some 8,000 Norwegian children have come to Denmark for 6-week holidays and convalescence trips.

Members of the Danish Railway Workers' Organization have taken 250



Despite their own shortages, the British have invited thousands of Dutch children, like these, to visit with them for a few months and get the food they need for health.

children of Dutch fellow workers into their homes for temporary care. About 100 Dutch children of Jewish descent, most of whom had spent several years in the Belsen concentration camp, have come to Denmark for convalescence. In addition, arrangements have been made for the billeting of some 3,600 Dutch children who were brought to Denmark for 3- and 4-month visits in groups.

Some 300 Belgian children were billeted in Denmark for 3 months and transportation home was provided for some.

After VE-day 872 French children spent 2-month vacations in Denmark. About 600 more were expected to come last spring to be followed by some 500 Polish children who were expected to spend the summer in Danish camps.

Denmark has also sent aid of various kinds to children in other countries. At one time during the war 80,000 children in Norway were fed by Danish food shipments.

Children in Belgium were the main beneficiaries of food shipped to that country during the war and right after VE-day. During the winter of 1945-46 additional food was shipped to sup-

plement the feeding of 4,000 school children in workers' districts.

Last winter 15,000 children in Paris received Danish food.

Since February of this year, 3,000 children in a suburb of Danzig, Poland, have been fed. The number is to be increased to 4,000 and distribution will continue for a year.

Food parcels have been sent to children in northern Italy; a meal a day has been served to 2,400 children in Hungary for a period of 5 months; and a gift of 100,000 food parcels for children has been accepted by the Soviet Union.

Denmark has also been very active in providing transportation for refugees of all nationalities to Denmark and elsewhere.

Eire

In the fall of 1945 about 100 French Catholic children between the ages of 10 and 15 came to Ireland under the auspices of the Irish Red Cross. They are expected to remain for a year and may remain longer. The children, not all of whom are orphans, live with private families and are supported either by the family or the Red Cross. Education is provided by the latter.

About 100 German Catholic orphans

between 10 and 15, taken from the British zone of occupation, are in Ireland this summer. They are cared for and educated in special institutions supported by the Red Cross.

France

Displaced unaccompanied children in France and in the French zone of occupation are treated as though they were French orphans. They are cared for by Assistance Publique a l'Enfance, a semi-governmental welfare organization, or by other welfare organizations, such as the semi-official Entr' Aide Francaise which is supported by voluntary contributions and government subsidy. The children live in orphanages or are placed with foster families.

Abandoned children found in other parts of Germany, one of whose parents is found to be French are being brought back to France by the French Red Cross. If the child's French parent can be found, the child is reunited with him. Children for whom no parent can be found are given to Assistance a l'Enfance, which shelters them until they are adopted by private families. Adoption procedures are being simplified for this group.

Oeuvre de Secours aux Enfants (OSE), a welfare organization which is supported both by the government and the JDC, is doing a large job for displaced unaccompanied and French orphaned children. OSE operates 20 children's homes and 26 dispensaries. In addition, OSE provides medical attention and specialized supervision for several thousand children not under its direct care.

In addition to the support given the OSE, the JDC supports 6 other welfare organizations in France. In all, some 10,500 children under 18 were being helped by JDC funds at the beginning of 1946. Almost equal numbers of these children were living in children's homes, with foster families, and with their own families.

The AFSC reports that it has fed children of stateless and Spanish families, and in 1944-45 assisted unaccompanied children in large refugee camps. Displaced children who accompanied American Army personnel returning from Central Europe were given into the care of the AFSC at Le Havre. After being registered so that their families might be sought, these children were transferred to the care of established French agencies. The Committee also gave supplementary care to Hungarian children found in Axis prisoner-of-war camps near Dieppe and representations were made through the International Red Cross for their release as minors and repatriation to Hungary. Children passing through France in transit to Palestine have received clothing from the AFSC. Some 20,000 children are fed daily by the AFSC through its package service. Some 50,000 children have been clothed.

The RRT offers food, clothing, and medical care to about 200 children of French and other nationalities at 2 children's homes, and to 350 children of all ages at a preventorium. In addition, it supports a children's home at Clairac which shelters 45 children between the ages of 9 and 12, half of whom are displaced. At Megane, the RRT is starting a new home which will specialize in occupational therapy for nervously disturbed children. About 40 children will be accommodated at one time.

Children from Austria, and Central European and Spanish refugee children spend 6-month vacations at a home at

Samsons which is also staffed and completely supported by the RRT.

Germany and Austria

JDC teams and RRT personnel are operating in Germany and Austria in cooperation with UNRRA, and are participating in all efforts to evacuate children from displaced persons camps. Between the end of hostilities and the first week in November 1945, JDC had evacuated 1,659 children from the area to France, England, Switzerland, and Italy.

The JDC is now supporting a child-care home near Hamburg which shelters 220 children brought there from the Belsen concentration camp.

Two AFSC representatives were pioneers in developing searching teams to locate Allied children in Germany. Cash grants have been given to the International Red Cross for displaced children in transit to the Russian zone of occupation. A relief team of AFSC workers is also administering temporary relief in Austria to German children in transit back to Germany.

The NCWC-WRS assists UNRRA with the support of 50 Polish orphans in an orphanage at Salsburg.

Great Britain

During the war, Great Britain was a haven for great numbers of refugees,

some of whom were unaccompanied children who were taken care of under the "War Refugee Scheme" set up by the Home Office in 1940.

Early in 1945 the British and Dutch Governments agreed that the Dutch Government might send a maximum of 20,000 children, not more than 2,000 at any one time, for temporary care in Britain. Some 7,500 Dutch children have come to England during the first year of this plan's operation. The children stay at hostels in the country for 2 or 3 months and then board with private families for 8 weeks. All expenses are paid by the Dutch Government which also sends teachers and helpers to accompany the children. The British Women's Volunteer Services has provided those children who need it with new clothing on their arrival in Britain.

Four hundred and fifty "lost" Jewish children are now sheltered in Britain. Three hundred children from the Theresienstadt concentration camp were flown to England by the Royal Air Force in August 1945. The majority of these children were Polish, but Hungarian, German, and Austrian children were also in the group. In October, 150 children from the Belsen concentration camp joined them at hostels in the English Lake District. These children are in England for temporary care pending

American food and care will pull this small Austrian, a victim of tuberculosis, back to health.





A group of Serbian boys, guests of the Swiss for a three-month period of supervised recreation and work, wash up at camp before getting their nourishing meal.

resettlement elsewhere, under the protection of the Jewish Refugee Committee and the Central Jewish Fund, to which the JDC also gives support. The children are receiving medical attention and general aid and rehabilitation, and will emigrate to other countries or may return to their native lands when conditions permit.

The Displaced Persons Division of the British Element of the Allied Commission in Austria has always accorded prior consideration to the care of homeless and lost children of non-Austrian nationality displaced in the British zone of Austria or rendered stateless by the war. As of March 1946, 9,250 such children were receiving special care in displaced-persons camps.

A special orphanage and three therapeutic centers for undernourished children are supported. No distinction is made in these homes between ex-enemy and United Nations nationals.

Plans are under way to repatriate 600 German children to friends or families in Berlin, and 100 Czechoslovak orphans to friends and relatives in that country. A home is also being sought in France for 49 French orphaned boys now living in the British zone.

Great Britain has formulated a policy to govern the entry of young Europeans in the future. On November 13, 1945, it was announced that "females under 21 with their children if any, and males under 18, who have no relatives to look after them abroad, but have a relative in the United Kingdom able and willing to take them into his household" will be admitted. Admissions will be subject to time limits to be reviewed periodically.

Also to be admitted under this plan are "other distressed persons who have been in hiding from the Gestapo or for various reasons are especially in need of care." This provision may allow additional unaccompanied children from concentration camps to enter the country even though they have no relatives there.

In November 1945, Britain also announced that naturalization, suspended during the war, would be resumed.

Greece

Very few displaced children are now in Greece.

Greece's Jewish children are aided by a general relief program conducted under the supervision of the local JDC representative.

RRT personnel, attached to UNRRA in Athens, assists with child-care activities.

Hungary

About 12,000 Jewish children under 18 are receiving general aid through the JDC. About 3,500, most of whom are half orphans, are living in 44 JDC supported children's homes. Many others are supported individually. JDC also distributes food in schools and gives vocational training to children over 14.

Italy

About 30 Polish orphans in civil refugee camps receive aid from the NCWC-WRS.

The RRT operates a children's clinic in Rome which dispenses special medical care to displaced children. Many are natives of Yugoslavia, Poland, Spain, and Central Europe. The clinic has recently expanded into a day boarding school.

In cooperation with UNRRA, the RRT supports a hospital in Naples which cares for 200 babies. Food and clothing have been given to the city's children.



Fed, clothed, and cared for in an American center, these children are back on the road to good health.

About 1,800 Jewish children under 18 in Italy are receiving general aid from the JDC. This number includes 300 children brought to Italy from Germany and Austria.

The Netherlands

Immediately after the country's liberation from German occupation several thousand unaccompanied children came to Holland. Though many of these were Dutch children who had previously been deported, many were of other nationalities. These children were cared for in camps run by the Netherlands Civil Affairs Administration.

Norway

Children born to displaced persons in Norway during the war may remain in Norway if they choose, or go to Allied countries.

Children born in Norway of German or other enemy aliens must return to their respective countries.

Poland

About 5,000 Polish Jewish children under 18 receive some kind of aid from the JDC which supports TOZ, a medical and child care agency. Institutional care, education, and medical and

psychiatric treatment, are among the services offered.

The RRT sends food and clothing to a recently established children's village.

Rumania

Oeuvre de Secours aux Enfants, a JDC supported agency, assists about 11,000 children in Rumania, 2,500 of whom are in children's homes. About 190 orphans live in an orphanage completely supported by the JDC, which gives general aid to about 26,000 children.

Spain

Since VJ-day a few hundred children have gone to Spain for temporary care. Soon after the liberation of Belgium 80 truckloads of food and clothing were sent to the children in that country by the Spanish Government. During the war, Spanish women made 150,000 garments which were sent to the Pope for distribution among needy children.

Sweden

Sweden's relief activities are coordinated by an official agency, the "Swedish Committee for International Relief Work" which administers government funds appropriated for relief

activities and delegates the actual operation of relief activities to other groups.

From 1941 until October 1943, 52,000 Finnish children had spent a total of 27,000,000 days in Sweden. These children, most of whom lived in private homes, have been in Sweden for periods ranging from several months to 4 years. Some 24,000 are still there, but all will eventually return to Finland.

About 2,000 Norwegian children spent the summer of 1945 in Sweden; 2,000 Dutch children and 500 Belgian children came for the fall of 1945; 3,000 Norwegian children spent the winter of 1945-46 in the country; and 1,000 French children are in Sweden this summer. These children were and are supported by Swedish funds. They live with private families and are given clothing if they need it.

Medical and hospital care is available whenever necessary. The children go to regular Swedish schools and if possible are taught in their native languages.

In the summer of 1945, through arrangements with UNRRA, 10,000 displaced persons, including 1,200 children and youth the majority of whom were unaccompanied, arrived in Sweden. Many of this group were Jewish, and nationalities represented included Polish, Hungarian, Rumanian, and Czechoslovakian.

All these young people were first cared for by the government in schools and youth hostels and later in 15 "school-homes."

In May 1946, some 900 of this group were still in homes. Some others are in hospitals and convalescent homes. Some of those over 18 were probably holding jobs and living independently.

The greatest majority of the Jewish children in Sweden want to go to Palestine. A small group would like to come to relatives in the United States, while smaller groups are eager to return to their homelands or to remain permanently in Sweden.

Swedish relief for children in other European countries is carried on mainly in Poland, Austria, Germany, Norway, and Finland.

In Germany and Austria, Swedish relief operations are directed only to children. As of March of this year, 64,000 children in those countries had

received Swedish food. More than 1,000,000 meals had been served at a Swedish children's soup kitchen in Vienna. During the first half of this year, 100,000 small children were fed daily in Berlin, Hamburg, Vienna, and the Ruhr. This program stopped on July 1 and will be resumed in the fall.

Finnish children have been given food since the 1944 Finnish-Russian armistice.

In 1942, with the permission of the Allies and Germany, and under supervision, Sweden started a feeding program for Norway's children and aged. In 1945, 156,500 children were fed.

In addition, Norwegian children received gifts of 50,000 outfits of clothing and 75,000 pairs of shoes from Sweden.

Sweden supports children's homes in Belgium, Yugoslavia, Czechoslovakia, and France, and children's hospitals in Poland.

The RRT reports that it has brought adolescents from displaced-persons camps in Germany into Sweden for vocational training and general rehabilitation. Many of these children grew up in concentration camps and never had any schooling.

Switzerland

One million children in Europe, the numerical counterpart of Switzerland's child population, are being fed every day for a 6-week period during the current famine emergency with food exported from Switzerland.

This special project is underway in addition to the country's long-standing program of relief and rehabilitation for children of all nationalities.

In August 1942, the Swiss Relief Committee for Refugee Children was charged by the Swiss Government to take care of every "lone child" under 16 who came to the country alone or with parents or relatives. From 1942 until the end of the war, some 4,800 children of 19 nationalities came under the Committee's protection and were housed with Swiss families, in special homes, or with their own families. About 1,280 of these children were unaccompanied. Since May 1945, 3,700 children have been able to leave Switzerland and have gone back to their homelands, to the United States, or to Palestine. The Committee is financially supported by Swiss relief agencies and the JDC.

Immediately upon the end of hostilities in 1945, Switzerland revived its wartime plan of inviting groups of children to come to its country for a period of recuperation. Under this plan, children come to Switzerland for 3-month stays. They are taken in by private families or sent to special homes if their health demands it. From the beginning of this plan to date, some 80,000 children between the ages of 4 and 14 have been cared for in this way: 62,000 came from France; 5,600 from Belgium; 7,800 from Holland; 3,000 from Italy; and 7,000 from Austria. The first 1,000 German children of 3,000 children scheduled to come from the French zone, and the first 450 of a scheduled 4,000 children from the British zone are now in Switzerland. In the summer and fall of 1945, 425 children and youth who had been in concentration camps were brought to Switzerland. Most are still there. Two hundred British and four hundred Polish tubercular children are now in Switzerland for 6-month rest cures.

A new Pestalozzi Children's Village will be opened in Trogen in October. Three hundred and fifty orphans of foreign nationalities will live in the village which will contain educational and hospitalization facilities. Groups of three to five houses will be set aside for youngsters of similar nationality but all groups will mingle during recreation and off-hours.

Since 1940, the Swiss Red Cross has been operating mobile canteens in areas of France in which there were large concentrations of refugees. Child colonies, nurseries, homes for expectant mothers, and other institutions have been opened and maintained. Similar help has been organized and carried on in Belgium, Finland, Serbia, Croatia, and Italy.

Don Suisse, not government sponsored, a private agency through which Switzerland coordinates all of its relief activities, has operated in 15 countries since 1944. It has a representative in Berlin who has helped organize relief work in that city and, with the cooperation of Russian officials, in the Russian zone of occupation in Germany as well.

An idea of its operations for children can be gained from excerpts from its activities' report covering the period

from February 16 to March 31 of this year.

During that 6-week period Don Suisse set up a good-sized food warehouse for children's homes in the Rhone-Alps region at Annemasse in France. A nurse was designated to visit each center to see what was needed and to check on use of the merchandise.

In Italy in the same period, provision was made to give supplementary food and clothing to 500 children in Florence during the months of March, April, and May. About 1,800 rations were distributed daily to mothers and children in the public kitchens and in 9 homes. (This is in collaboration with Caritas and UNRRA.) Don Suisse assistance made possible the reopening of a children's home in Trento run by the Swiss Committee for Aid to Italian Children which cares for 100 children. This assistance will continue for 6 months. Food was sent to children in Piedmont and to 500 children in Brescia.

In Austria, children's homes and centers were opened in Vienna and in lower Austria. Some 25,000 young children received care. In addition, 677 kilograms of wool and 20 sewing machines were sent to Austria to be used for the making of children's garments.

To Hungary went 25,000 kg. of julienne soup for the children of Budapest and other districts.

Material for the construction of 29 huts went to Poland. In a year 5,000 children will be able to spend 6-week vacation periods in them.

Relief activities for German children were organized at the end of 1945. Comprehensive child-care projects are in operation in the Rhineland and in Berlin and special attention goes to children of displaced persons.

The JDC reports that it helped support 2,000 children in Switzerland after their deportation from France, and that it had transported 300 children from Germany and Austria to Switzerland.

RRT reports that it operates a children's home near Zurich, and that since 1943 it has operated a rest home near Geneva where numbers of families, sheltered in separate places, may be remitted for brief periods.

Yugoslavia

JDC reports giving general relief services to about 1,000 children under 18.

UNRRA SHELTERS UNATTENDED CHILDREN

MARION E. HUTTON *as told to* GEORGE ELLISON

Until March 1946, Miss Hutton served as deputy director in establishing and operating the center for unaccompanied allied children at Kloster-Indersdorf, near Munich, Germany.

She began her social work career in 1936, being connected with public agencies until 1940 when she went with the USO-Travelers Aid which was establishing programs of services for people being dislocated by war industries and military service.

In 1943 while serving as director of USO-Travelers Aid at San Luis Obispo, Calif., she resigned to enter the Women's Army Corps. She was stationed for most of the year in Bradley Field, Conn. In December 1944, she was released to go overseas with UNRRA.

She joined UNRRA team No. 128 in France from where she went to Germany for her work with displaced children.

Mr. Ellison is a member of the staff of the Division of Reports.

I WANT you to think of a 15-year-old boy in your neighborhood. The son of the grocer in the next block for instance. Maybe you remember when he was born. At least you can remember when his brothers and sisters were born. Keep this boy in mind because I am going to tell you about such a boy.

He was 15 years old when the Nazis conquered his country. He was the oldest son of a tailor in Berbest, Rumania. Next to him was a sister, then two younger brothers, and the baby—a little girl.

In March of 1944, the Storm Troopers began arresting the Jews. They took the tailor and his family to the Oranienburg concentration camp. The baby was 2 then.

This 15-year-old boy saw his father shot to death. Then his mother and baby sister were taken to the gas chambers.

The Nazis didn't keep the four remaining children long at that camp, but with many other children, sent them to another at Auschwitz. After a month they were transferred to still another camp, Auschwitz 3. Their stay there was short, less than a month.

It was late winter when they were ordered to march again. Exhausted, the two smaller boys began to lag. The older boy and his sister tried to help by carrying the little ones. But the Nazis

would not allow that. When the 15-year-old boy last saw his little brothers, they were huddled together on the roadside.

At the next camp—Gleiwitz—the sis-

At the Kloster-Indersdorf Monastery, Bavaria, UNRRA Team 182 cares for 200 children at a time.





When Hitler came to power he drove the Sisters from their orphanage; when the war was over they came back to help UNRRA's children.

ter became lost from the boy. He had not found her or heard from her when he was moved to another camp. It was Oranienburg again—from which he had started his wanderings. He was kept there until February 1945, when he was sent to Flossenburg.

In April on the way to Dachau concentration camp, the American soldiers caught up with the marchers. The GI's took this young boy and cared for him in their billet until he was brought to an old monastery outside Munich where I first saw him.

It was there—in the eastern military district of the American zone in Germany—that UNRRA team No. 182, at the request of the Displaced Persons Division of the Third Army Rear, had set

up an operational center for allied displaced children.

Since VE-day, nearly 9,000 boys and girls with experience similar to those of the 15-year-old Rumanian boy have been given care by UNRRA in unaccompanied children's centers in the United States and British occupied zones of Germany.

A year has passed since the liberation of these children and only comparatively few have been returned to the country of their origin or resettled in some other country. That no adequate opportunity has yet been provided for permanent settlement for a majority of these children is an international tragedy.

Besides unaccompanied children in centers in occupied Germany, approxi-

mately 51,000 displaced children under 14 years of age are living with their families or other responsible adults in displaced persons' camps. Nearly 27,000 of these children are under 6 years of age.

At the present time, the United States zone has 6 children's centers; the British zone 14.

Centers are set up in locations where the Allied Military Government—which has responsibility for the entire displaced persons' operation—finds that they are needed. UNRRA personnel supervises the centers.

The unaccompanied child—that is, the child who is alone and with no relatives or responsible adults to take care of him—was early recognized as the real problem of the displaced children.



↑ School doors were closed to these children for many years, but now they happily report for class before the bell rings each day.



↑ Thanks to UNRRA, they have a chance to undo ills of starvation. ↓ This "sewing bee" is only a few months from slave labor.



His legal rights and status are in question. Frequently not only his identity must be determined, but his nationality. Practically all such children are in need of convalescent or other specialized care.

In the British zone centers, unaccompanied children are placed in small homes near the regular assembly center, frequently in charge of displaced couples from their own country.

Unaccompanied children in the United States zone are placed in much larger numbers under one roof where it is easier to provide special child-care facilities.

Such a center is Kloster-Indersdorf, located near Dachau concentration camp, outside Munich, to which the 15-year-old Rumanian boy was brought. The building is centuries old. Originally a monastery, it was later converted into an orphanage by members of the Order of St. Vincent de Paul, who operated it until Hitler removed them in 1938.

When UNRRA took over the place, it still had some of the old orphanage equipment and this was put to use when it was opened to receive Allied displaced children in July of 1945. To assist in operating the center, UNRRA team No. 182 asked the Sisters to come back.

Nearly 200 are sheltered in the old monastery at one time. Almost any boy or girl there can match in horror and suffering the story of the 15-year-old son of the Rumanian tailor.

For instance, there were the two Polish boys of 16 who worked in the crematorium at Auschwitz, stoking the fires that would consume the bodies of those who had died or were killed in the night.

There was the Jewish boy of the same age whose job it was to cut down the bodies of those who had been hanged.

There was the 17-year-old girl who was forced to work from 12 to 18 hours making shell casings. When her work lagged she was given 25 lashes with a bull whip, and at times sprayed with cold water to prevent fainting.

As a result of their years of suffering and ill treatment, these young people tend to be keenly analytical of others' motives, and deeply apprehensive of any movement affecting themselves which is not fully understood. Even then, they maintain a reasonable degree of skepticism.

Kloster-Indersdorf is neither the largest nor smallest of the centers in the United States zone. Its work with the unaccompanied child is similar to that of Elizabethan Heim at Deggen-dorf, Struth near Amberg, Aglasters-hausen at Ulm, Wartenburg near Wartenburg, and Wolfratzhausen in the town of Wolfratzhausen.

The main hope of those of us in charge of the children in those centers was to give them a home. But a home means more than food, shelter, and clothing. We worked not only for the physical welfare of the children, but also for their emotional welfare. Although we could not completely supply the greatest need of the individual child—that of home relationships—we tried to approximate it.

Our entire program and everything that we did was for the welfare of the child—that rather than for the convenience of national governments, agencies, or personnel of the center.

The older children spent a large part of each day in study. Whenever possible instruction was in the native language. However, some of the classes were conducted in German since most of the children spoke that language. Getting sufficient equipment for these schools—especially text books—was a serious problem.

In planning for their future, many of the children said they wanted to become cooks, or bakers, or tailors. Such choices were frequently made because those professions represent things that have often been denied them, such as food and clothing.

Agriculture and farming interested a great many of the children. They received training on 18 farms which were operated in connection with the centers in the United States zone.

From a weekly report of Kloster-Indersdorf, selected at random, some idea can be given of the nationality and age of the children. At the time of this report, the largest number from any one nation was Polish. Forty-seven were Jewish of various nationalities. The youngest Jewish child was a boy of 7. There was a gap of 7 years between this child and the other Jewish children.

Boys outnumbered girls in the Kloster-Indersdorf center. That, however, was not the case in all displaced children's centers. Certain sections of

the British occupied zone had more girls than boys.

Of all the children at Kloster-Indersdorf, ages fell roughly into two main groups: those under 3 years, and those in their late teens. Few children of the in-between ages had survived the rigors of concentration camps, child labor, and other hazards of war conditions.

Twenty-two nationalities were in the center. In some instances nationality could be determined only roughly by name and racial characteristics. Among the nationalities were: Austrian, Belgian, Czechoslovakian, Danish, Dutch, English, French, German, Greek, Hungarian, Latvian, Lithuanian, Norwegian, Polish, Rumanian, Russian, Ukrainian, Yugoslavian, and one who claimed to be a citizen of the United States.

This boy, who was 14, said that his father was a nationalized citizen of this country. As a very young child, he had been brought to Germany to stay with his grandparents. The home of the grandparents had been bombed and efforts of the UNRRA staff to locate the grandparents had failed. The boy was able to give only a few leads as to the whereabouts of his father in this country. To date he has not been located.

Although all the children were without homes and unaccompanied by members of their families or other relatives, their wartime backgrounds made wide differences in their experiences.

Many who had been in concentration camps were the only member of their family still alive. For the most part, these were Jewish. Some had survived with a brother, a sister, or a cousin whom they had lost trace of and whom they made frantic efforts to locate. They were filled with anxieties about relatives and efforts being made to trace them, and apprehensive about their own future.

With very few exceptions they shared a deep-seated animosity to all Germans and all things German. When a group of these children was being transferred to England by air, the question asked most often was "Are we out of Germany yet?"

As each country was conquered the Nazis had gathered large numbers of non-Jewish children who were sent back to Germany to work in factories or on farms for the purpose of Germaniza-



↑ It takes a lot of mothering to make these young orphans happy.



↓ Slowly the young girls learn how to mother their young charges.





↑ Group care has had to replace family care for these small tots.



↓ Clothes and questions ↓ are important as they begin a new life.



tion. These children, taken from parents and families, were placed under teachers and group leaders in Germany.

Thirty Polish girls at the center had had this experience. They were a part of a larger group from a village in Silesia. In January 1945, the Nazis took them from their school on the pretext that they were going on a "holiday." They were placed on farms in Germany.

When they were brought to the UNRRA center, most of them were in rags, all showed marked effects of malnutrition and mental anxiety. Their hair was a mat filled with lice. All had skin infections, two so seriously that they were unable to wear shoes. Their feet and legs were wrapped in dirty blood-stained gauze. Some were so confused that they thought themselves German.

Some of the children at the center told of experiences that were difficult to believe. Three Yugoslavian brothers, taken from their home in Serbia by Storm Troopers, had worked in several places in Germany. The stories of what they had seen—the methods used by the Germans in persecution and death—were of such nature that two UNRRA workers made independent effort to determine the probability of fantasy.

About 20 babies, children of mothers who had been taken to Germany to work on farms and who were not permitted to marry, were found in German foster homes, hospitals, and institutions. Many of them did not live long enough to be brought to the center. Those who were taken in by the center were usually in poor condition but responded favorably to care.

Another group at the center were children of allied displaced persons. Usually they were orphans or presumed to be so. Their parents had either died in Germany, been killed in bombings, or had been separated from them in the confusion of war conditions. Some of the children had been placed in an institution, foster home, or hospital temporarily. Their parents had not returned, possibly because of shifts in population or transportation breakdowns.

Nothing was known of one group of babies except the name and nationality of the mother, the given name of the baby, and the birth date.

These babies were children of Nazi

fathers and girls of the various conquered nations. They had been gathered from Nazi maternity homes located through the conquered countries and Germany. Records of the institutions were not available at any time to local organizations and agencies. In fact, at the time of the liberation by the American Army, records were said to have been destroyed. Many of the infants suffered from malnutrition, emotional disturbance, neglect, and shock.

The children most recently brought to the centers were those who had been located by UNRRA searching teams which had scoured the United States zone for "Germanized" children. UNRRA workers believed that most of these children were transferred to Germany during 1943 and 1945.

Some of them had been brought to increase the German population, or to be developed into farm laborers. Some were refugees who had escaped the battle lines. They were found "hidden" in German homes and institutions. So well had the children been indoctrinated that only by patient detective work were searching teams able to disprove claims of German birth.

Most of the older children who were located were identifiable, but the majority of the rest were too young when they came to Germany to remember their true names and in some instances their nationalities.

After the children have been found, the UNRRA Central Tracing Bureau begins the work of locating families. Allied liaison officers determine the repatriation status of the children. Although most of those identified are Polish, also found are Czechoslovakian, Hungarian, Yugoslav, and Ukrainian children.

With the tapping of these "hidden" sources of allied children, the number of unaccompanied children in the United States zone is steadily increasing, despite the repatriation and immigration programs which are already underway.

In addition to the groups already arrived in the United States, 800 Polish children are awaiting rail transportation for their return to Poland. The Polish Red Cross is supervising their repatriation.

Fifty Jewish children are now ready to go to England on individual visas to

join relatives in the United Kingdom. Last fall England received from the American zone 100 Jewish children for temporary care pending resettlement.

A majority of the 400 unaccompanied children transferred to Switzerland for recuperation are now in the process of repatriation or immigration from that country. Included in this group are about 50 Polish children who will return to Poland by the train that is to bring 400 ill Polish children to Switzerland to recuperate.

Children in the group in Switzerland who as yet are unidentified—a very small number—will be returned to occupied territory where UNRRA will try to establish their identity and arrange for their repatriation and immigration.

The largest individual group to go from the centers to new homes is composed of approximately 600 Jewish children who went to Palestine on entry permits.

These children, ranging in age from 3 to 19 years, traveled by train from the occupied territory to Marseilles, France, from where by boat they sailed for Haifa. Most of them plan to join collectives in their new country.

The trip across Germany and France to the port took 4 nights and 3 days. The poorly equipped train was cold, windows were broken, drinking water was carried by UNRRA workers in dairy pails, and the only places to sleep were on the hard, uncushioned seats. But the children were in high spirits. At each stop of the train as they crossed Germany, in the station yardway they sang and danced Palestinian songs and dances. The hostile air of the German people along the route did not change. In fact, the train traveled in a hostile country until it entered France. The French people not only cheered the dancing and singing of the children but brought food and water to the train. Food is as scarce in France as it is in Germany.

When one of the UNRRA workers regretted that the trip was being made under such hardships, the children—some of them veterans of as many as eight concentration camps—laughed. They said: "It is nothing. Hardships? It is worth them all. We are going home."

A NATION CARES FOR ITS OWN

ZLATKO BALOKOVIC, President. *American Committee for Yugoslav Relief*

Displaced children—unaccompanied children living outside their own country—present problems which do not arise among children living in their own country, under the care of their own government. But the number of displaced children is small compared with the millions left homeless and orphans by the war. The countries of Europe which have been most devastated by the war, which have suffered the greatest loss of

buildings and equipment, also face an enormous problem in the mass care of children. Millions must be housed at once, and many of them will have to develop personal and social patterns without the normal family contacts. The situation in Yugoslavia, described by Mr. Balokovic of the American Committee for Yugoslav Relief, illustrates the problems being faced in many parts of Europe today.—Ed.

TODAY, Yugoslavia is a country of 14 million people—about one-tenth the population of the United States—and it is faced with the problem of caring for 1,200,000 orphan or half-orphan children under 15 years of age. These children should have security—a place where they feel they belong, intimate contact with adults who know them and love them and will remain with them, an orderly life built around school work. All these things must be supplied if this generation of Yugoslavia's children is to grow into healthy, useful citizens. But there are certain material needs which must be met before these problems can be touched.

First, the children must be housed. And

there are no buildings. Houses and entire villages have been destroyed in all parts of Yugoslavia. Some have been bombed and some have been dynamited by the Germans as acts of reprisal. In the most affected area there is not one building standing along a 125-mile stretch of highway. The children must also be fed. And there is very little food in Yugoslavia.

A few months ago—the latest date for which I have any figures—20,000 children had been sent into Bulgaria where food is more plentiful. They are to remain there until they put on a little weight and then return to their own country. Other children had been moved from the badly damaged areas in southern Yugoslavia to the slightly

more prosperous northern section. Shelter had been provided for a bare 16,500.

The need for shelter of any kind is so great that other factors—comfort, mental health, or even rudimentary hygiene—cannot be considered. Any family that has a roof at all takes as many children as can possibly be stowed among them. Frequently these families cannot afford to feed or dress the children and the government must do that for them. In some places large buildings that have been partially destroyed have been made into temporary orphanages. Here the children sleep on straw placed on tiers of wooden shelves. Others are being housed in army tents and barracks.

One sometimes forgets that when buildings are destroyed the materials in them are destroyed too. But in Yugoslavia the ordinary household furnishings—bedding and cooking pans, spoons, bowls, cups—are harder to find than shelter. There is practically no equipment in these children's barracks. There is, on an average, 1 spoon for 20 children, 1 cup for 50. And there is no soap at all. It is impossible to prevent the spread of mouth infections. And the children are so weak that simple diseases, such as measles, are often fatal.

When villages were destroyed and populations scattered, children who became separated from their parents tended to attach themselves to the Army. Boys who would be considered very young in America—10 and 11 years old—carried guns and engaged in regular fighting. Still younger children were used to carry messages, which they memorized. The casualties were great. There are 10,000 children under 15 years of age who have lost a limb. One 11-year-old Army courier has asked me to send him an arm from America. A large number of small children have been blinded by mines. These casualties require long-time care and expensive equipment. And they do not have the doctors or equipment to meet the more acute needs. They have 12,000 children with diseases of the bones and joints and only 700 hospital beds set aside for such cases. They have 150,000 open cases of tuberculosis and 5,000 beds for them.

In the large cities of the United States we have, on the average, 1 doc-

tor to every 700 persons and in only one-third of the counties of the United States are there fewer doctors than 1 to 2,000. In Yugoslavia there is 1 doctor to 4,500 people and they are concentrated in areas where there are hospitals and other equipment. Great stretches of country have no medical service at all. In one place an English woman doctor, with 2 nurses, is operating a mobile clinic and serving 20,000 people.

Under the circumstances I have described, psychiatric services may seem like a luxury they could not afford. But they also have a pressing mental-health problem. One-third of the homeless children of Yugoslavia have been in concentration camps. The number is as small as it is because children did not live very long under those conditions. They were crushed physically and mentally and died in large numbers. In

one camp, taken over at the close of hostilities, 1,500 children were found alive among the unburied dead. In order to care for these children, it was necessary to move them to a less devastated part of the country. Five hundred died while being moved, and another 300 soon after they reached their new home.

These children are physically sick and badly shocked. They cannot realize that a change has taken place. Their nights are disturbed by frightful nightmares from which they wake screaming. Most commonly they dream of fire—burning homes and burning villages. During the day they are apathetic, and utterly listless. I was told of one little girl who was taken by the Germans when she was 8 years old and kept in solitary confinement for 3 years because she would not tell where her parents were. This child, like many others from

A Yugoslav child, who cannot understand death, cries for the love and attention he used to know.



the concentration camps, will not put out her hands when food is offered to her because she was frequently tortured by having food set before her and taken away as soon as she reached for it.

Beyond doubt, these children are the worst casualties of the war. So much will have to be done for them if they are to be brought back to life. And so little is known about such states of mind that the best plans for them can only be guesswork.

Reports are reaching the United States that the people of Europe are "tired"—that faced with the wreckage of everything they loved, they cannot find the energy to start again. This is a very understandable reaction to calamity, but it is not an inevitable one. It is not true every place. And it is not true in Yugoslavia. An enormous need sometimes crushes men, but it may also have the very opposite effect. The unprecedented demand may release a great creative impulse. This is what has happened in Yugoslavia. Today the people are working with an energy inconceivable under better circumstances.

This applies to children as well as adults. Those children who were not in concentration camps may be maimed, or malnourished, but they do not present problems in mental hygiene. They are carrying responsibilities and performing an amount of physical labor that would be unthinkable in the United States. But they are doing it gladly. They know that they are effective members of their communities. And this offsets many of the evils we normally associate with child labor.

To begin with, these children are more mature than American children of the same ages. In Yugoslavia full suffrage is granted at 18 years of age, not at 21 as in the United States, and to all citizens who have borne arms, regardless of age. They have 10,000 children between 13 and 18 years of age who are entitled to vote. There were 14-year-old lieutenants in the Army. And even much younger children are used to a great deal of responsibility. A friend of mine tells me that her 9-year-old son was active in a resistance organization. She learned this indirectly, not through the boy who did not tell his mother what he was doing because the knowledge was too dangerous.

These children are now carrying

"To think of the children gives renewed strength to a decent man. They are worthwhile! They are the incarnate future-tense of mankind! They are the seed corn of the race! The love of children is the one universal bond that across all racial and national lines makes all mankind akin! The cooperative world, organized for peace, that, like the fools we are, we have refused to build for our own sakes, we may be wise enough at last to build for their sakes. So we will keep the faith and not surrender. We will not let the children down."

Dr. Harry Emerson Fosdick.

shovels as proudly as they carried guns. They are helping to clear away the rubble of cities. Last summer children as young as 7 were helping to pull the plows. The children of Yugoslavia enjoy sport as much as American children but the work of clearing and plowing is so important that there is no time for sport. Under these circumstances the children are finding in work a great many of the satisfactions they would normally find in games.

All these things are emergency measures. Yugoslavia is still facing the emergency. They are desperately in need of barracks, spoons, cups, and all ordinary equipment. After they have these things, they can make better plans for the long-time care of their orphans. Children need love and close contact with adults as much as they need material things. It is hoped that in time these children can be placed in groups of 20 under adults who will also be their teachers. This means the healthy minded children, of course. The sick and shocked will need special attention. But a great deal more will have to be known about these children before plans can be made for them.

Individuals in the United States are helping the children of Yugoslavia in many ways. Some, working through the Yugoslav Red Cross, are taking full responsibility for feeding and clothing a particular child. But Yugoslavia looks to America as a nation chiefly for help in its education programs. In the elementary schools the children are learning English and Russian—usually taught by other children who have been attached to the Russian or American Armies. Plans are being made to supplement this with a Red Cross project in which Yugoslav children will exchange letters with children in America.

The advanced and technical schools are badly handicapped, right now, by lack of equipment. They lack microscopes, and precision instruments of all kinds. But even if they had all the equipment they could use, they would still look to America for help. They would like to have instructors from America, particularly for industrial skills. And they would like to send some of their students to America for industrial training. This cannot be arranged until after the peace settlements have been made.

Yugoslavia has much in common with the United States. The present widespread devastation, calling for extraordinary endurance and labor, is having somewhat the same effect, psychologically, that the frontier had in the development of America. Both nations are to a certain extent independent of the traditions of Europe. Both are young; they have the merits and the weaknesses of youth. The people of Yugoslavia feel a kinship with America. They believe they understand Americans and that they can learn from us more easily than from their European neighbors. They are now facing an emergency situation for which there is no precedent and which must be met in whatever way it can. But in the long-range planning for all their children, they hope to make great use of American experience and American advice.

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IF THERE IS TO BE HOPE

The articles in this special number of **THE CHILD** portray vividly and with great poignancy the children who with courage, dignity, and resourcefulness have endured persecution, torture, and grief beyond anything the modern world has known. To come to know them even through the written page gives renewed faith in the resiliency and essential goodness of human nature. These young people have become mature beyond their years, yet they are groping for satisfactions of childhood's basic needs—security, affection, a sense of belonging; and opportunity for growth, for self-improvement, for a chance in the world.

We in the United States, whose children have been sheltered and protected during these years of oppression and war, have the great privilege of providing new homes and a fresh chance to some of these war victims. The number is pitifully small measured against the need, but each one given a chance to realize his longing for a home, for folks, for an education, represents a triumph of light over darkness. We must open our doors to as many without families of their own as desire to come and can be admitted under governmental and intergovernmental policies.

In far greater numbers, the children who must remain overseas call to us for aid through governmental and volun-

tary channels. They need food first of all, and then whatever assistance can be given in reestablishing them in home and community life. In addition to services by UNRRA the record of the aid given by voluntary agencies in the United States, by Sweden and Switzerland, and especially by countries which, though severely damaged by war and occupation, have shared their meagre resources with the children of countries in a still more desperate plight, are impressive. Yet all that has been done is tragically little in the light of the appalling numbers of homeless and suffering children and youth. It is imperative that more adequate assistance be given through comprehensive plans developed under international governmental auspices.

It is, of course, essential that all services for the children of war-devastated lands be based upon full understanding of the needs of children, the conditions under which they are now living, and the experiences to which they were subjected during war and occupation. Such concern must extend to children of former enemy as well as formerly occupied lands, for children everywhere must be given their chance at life, hope, and fulfillment if there is to be hope of peace and security for our world.

How to overcome the bodily damage and the stunted development resulting from years of deprivation and under-feeding are matters for the physician,

the nurse, the nutritionist, and the social worker.

Even more difficult are the problems involved in overcoming the family and social deprivations that have stunted and twisted the minds and spirits of millions of youth.

We have learned much, in the period between the two world wars, of the secrets of mental and emotional life and the ways in which maladjusted individuals can be helped to develop normal ties and socially desirable attitudes. Many different professions have contributed to this understanding, and much money has been invested in making possible the practice of mental hygiene and social service. Let us mobilize all possible resources to bring to the assistance of the peoples and the governments of the countries devastated by war the fruits of modern knowledge and skill, sure that in serving their great need we shall be enriching our heritage of understanding and of skill.

Beyond all, the lives of the children written about in these pages and the deaths of countless numbers of their generation should engrave indelibly upon the conscience of mankind the terrible effect of modern war upon the innocent, and the necessity of building a just and lasting peace.

Katharine F. Lenroot
Chief, Children's Bureau.

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THE CHILD



A FIRST PROTECTION FOR THE CHILD BORN OUT OF WEDLOCK

HELEN C. HUFFMAN, *Social Science Analyst*
National Division of Vital Statistics, U. S. Public Health Service

JOHNNY DOE, 17 years old, comes to the counter in a vital-records office and asks for a copy of his birth certificate. He needs it to get a work permit.

The clerk gives him a request form to fill in. On this form he writes his name, John Doe, his mother's maiden name, Mary Smith; his father's name, Henry Doe; and the date and place of his birth.

The clerk takes the request form and looks in the index under "Doe, John," but finds no record. Then she looks under "Smith, Mary," and finds a record of Johnny's birth. But the item, "Name of father," is blank, and the item, "Legitimate?" is answered "No."

What should the clerk do now? She doesn't know whether Johnny knows that he was born out of wedlock. Perhaps his father and mother have married since his birth, and his birth thereby has been legitimated. Or perhaps he has been adopted.

Should this clerk let the boy have a copy of his certificate, and let him learn of his illegitimate birth in that way?

This situation is one of the many that arise out of the complicated problems of the child born out of wedlock.

The birth record provides the information that the child needs in entering school, in leaving school for work, and even in entering employment during vacation or outside school hours. Or if he is left property. Or if he needs a passport.

The record of each birth in the State is needed as basic information in planning programs for the health and wel-

fare of the community, and in finding out how these programs are progressing.

To accomplish these purposes it is necessary that the information asked for on the birth certificate be given accurately and completely.

The child has a right to a record embodying accurate and complete facts. False information is sometimes given on the birth certificate of a child born out of wedlock. This is against the best in-

terests of the child, in many ways. For example, if his birth is later legitimated, a fictitious name on the certificate for his father or mother makes the legitimation difficult to record. In some States open court proceedings are necessary to cancel a fictitious name before a legitimation can be recorded.

Confidential handling

But if we expect to obtain accurate and complete information on the birth records of children born out of wedlock, we must be able to say truthfully to the mother, and to the doctor who fills out the certificate, that the information will be kept confidential. In most States the records are guarded against misuse. But in some, birth records are open to the public, and are thereby available for examination by credit companies, by firms wishing to sell their products to mothers, and by persons merely curious. In these States a social worker advising an expectant mother against using a fictitious name is in a dilemma. For though the worker knows that the child has a right to a true rec-



ord of the facts, she cannot assure the mother that the information on the birth record will be kept under lock and key.

Certified copy of birth record

Now that the birth certificate has come into general use as documentary evidence we need a method by which a person can present a certified copy of the items needed for general purposes, such as entering school or getting a work permit, without having to reveal the contents of the entire document. A child who is asked to show a birth record in order to get a work permit should not have to show a paper revealing that he was born out of wedlock. Nor should it show that the child had a birth injury, that his mother had syphilis, or that his father was in a penal institution or a hospital for the mentally ill. Some records do contain statements of this kind.

In most States it is still the practice to issue a complete handwritten or

photostatic copy for use in proving age or citizenship. And if a complete copy is the only copy that a person can get, he is forced to show the whole document whenever proof is needed of any item on it.

Social workers, registrars, and others have for years advocated the use of partial certified copies. Some States now issue partial copies to persons of illegitimate birth. But the practice of giving a special form to persons of illegitimate birth tends to set this group off as different. And this defeats the purpose of the form.

Within the past year the Council of the American Association of Registration Executives has introduced a new type of partial certified copy, for use when proof of age or citizenship only is required. This is called the birth-registration card, or, more commonly, the birth card. It is a wallet-sized card, sealed in a tamper-proof laminated cover. It bears only the person's

name, sex, date, and place of birth, and the number of his birth certificate. Eight States, California, Georgia, Mississippi, Nevada, Ohio, Oregon, Tennessee, and Washington, and the city of New Orleans have begun using the birth card, and all report satisfactory results. Several more States are planning to use it.

The birth card does not provide proof of parentage, and therefore the council has devised a "confidential verification" for this purpose. Through the confidential verification the vital-statistics office makes available to authorized agencies, such as the Veterans Administration and the Bureau of Old Age and Survivors Insurance, any information that a person wishes the agency to have from his birth record.

These two devices—the birth card, used to prove age and citizenship, and the confidential verification, used only to prove parentage—will permit a per-

On the right we see the Standard Certificate of Live Birth, which was prepared by the U. S. Bureau of the Census as a model for State vital-records offices. All the States use this certificate; many of them have made modifications. The certificate is revised every 10 years; the 1949 revision is now in process. On the left is a birth card, which gives the information needed for most uses, but omits parentage and many other items that are on the full certificate. States might well consider whether or not the item "race" is essential on the birth card.

DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS		STANDARD CERTIFICATE OF LIVE BIRTH		Form Approved BUDGET BUREAU No. 41-R133-42	
State of _____		State File No. _____		Registrar's No. _____	
1. PLACE OF BIRTH: (a) County _____ (b) City or town _____ (c) Name of hospital or institution: _____ (If not in hospital or institution, give street number or location) (d) Mother's stay before delivery: In hospital or institution _____ In this community _____ (Specify whether home, in mother, or elsewhere)		2. USUAL RESIDENCE OF MOTHER: (a) State _____ (b) County _____ (c) City or town _____ (If outside city or town limits, write RURAL) (d) Street No. _____ (If rural, give location)			
3. Full name of child _____		4. Date of birth _____ (Month) (Day) (Year)			
5. Sex: _____	6. Twin or triplet _____	If so—born 1st, 2d, or 3d _____	7. Number months of pregnancy _____	8. Is mother married? _____	
FATHER OF CHILD			MOTHER OF CHILD		
9. Full name _____			15. Full maiden name _____		
10. Color or race _____			16. Color or race _____		
11. Age at time of this birth _____ yrs.			17. Age at birth _____ yrs.		
12. Birthplace _____ (City, town, or county) (State or foreign country)			18. Birthplace _____ (City, town, or county) (State or foreign country)		
13. Usual occupation _____			19. Usual occupation _____		
14. Industry or business _____			20. Industry or business _____		
21. Children born to this mother: (a) How many other children of this mother are now living? _____ (b) How many other children were born alive but are now dead? _____ (c) How many children were born dead? _____			22. Mother's mailing address for registration no _____		
23. I hereby certify that I attended the birth of this child who was born alive at the hour of _____ m. on the date above stated _____ given was furnished by _____ related to this child as _____					
24. Date received by local registrar _____			Attendant's own signature _____		
25. Registrar's own signature _____			M. D., midwife, or other _____ Date signed _____		
26. Date on which given name added _____ by _____ (If other)			Address _____		

use to use any part of his birth certificate without being forced to give information that is not needed in the situation and which he wishes to withhold. For the child born out of wedlock, they have the additional advantage of providing a certified copy that is in the same form as those issued to other persons. The general use of the birth card and the confidential verification in all the States seems most desirable.

Thus far we have been concerned primarily with the practices that should be followed with regard to the birth records of all persons.

In addition to general measures, it is necessary that we build up certain protections around the record of the person of illegitimate birth because of his unique position insofar as his birth record is concerned. His record cannot be considered complete and final at birth.

Take, for example, his name. He simply has no surname to be placed on the birth certificate. Under the common law he has no right to any name until he acquires one through use; therefore, any name placed on the certificate at birth is at best only a declaration of intent to call him by that name. Some time must elapse before he has a legal name to place on the record.

Another example of the lack of finality of a birth record is in connection with legitimation. In some States, if the natural parents marry after the child's birth, the birth is considered to have been legitimate from the beginning and the statement of illegitimacy on the original record is legally erased.

The methods of safeguarding the records of children born out of wedlock differ according to whether the child is adopted, is legitimated by the marriage of his parents, or remains in his original status.

The adopted child

For the protection of the adopted child, whether he was born in or out of wedlock, it is essential that the State have legislation requiring courts to report all final decrees of adoption to the vital-records office. It is necessary, too, that the original certificate and the report from the court be maintained in a closed file, to be opened only upon court order, or upon request of the adopted person when of age.

Until such time as the birth card replaces the complete certified copy, legislation in the States should provide for the preparation of a new certificate after adoption. This is now done in nearly all the States, although there are variations in this procedure which need further consideration.

At the request of the Council of the American Association of Registration Executives, a manual of uniform policy and procedure on adoptions is being prepared by the Division of Vital Statistics. It will embody the best practices we now know for protecting the record and the child. Similar manuals have been requested by the Council for handling the records of the child born out of wedlock who has been legitimated and the one who retains his original status.

The legitimated child

In regard to the record of the legitimated child, it is important that the vital-records office receive proof of the marriage of the parents and the husband's acceptance of paternity. This properly documents the legitimation and makes it possible for future certified copies to reflect the true picture.

Until the birth card has replaced the complete copy, State laws should provide for preparation of a new certificate for legitimated children and also for sealing of the original records and the proofs of legitimation.

The child born out of wedlock whose status remains unchanged

A different approach must be taken in safeguarding the records of children whose status of illegitimacy remains unchanged. This is by far the largest of the three groups and is the one for which the least has been accomplished. Many persons have been aware of the problem, but until the registration officials were able to effect a plan to protect *all* birth records, attempts to solve it were at best only patchwork measures.

Before the birth card can meet the certified-copy problem of all children born out of wedlock, it must carry the name by which a person is known.

If, for example, I am known as Mary Smith and I receive a birth card bearing the name of Mary Halkovich, it is of no use to me. In most States it is now the

practice, although it is not required by law, to place the mother's maiden name on the original record as the surname of a child born out of wedlock. This presents a problem to the many such children who acquire through usage a surname different from the mother's maiden name.

To meet this difficulty, two States, Georgia and Maryland, now permit a person to present proof of name to the registrar and thereby have his acquired legal name added to the record. A confidential procedure of this kind eliminates the cost and publicity connected with the obtaining of a court order to correct the surname on the birth record.

In California, Maryland, and some other States the mother at the time of the child's birth may give the surname that she expects him to bear, and this name is placed on the original record. Of course, at the time the child is born, the mother does not in all cases know what name the child will bear. In one State, Georgia, unless the father has consented to the use of his name, the surname of the child born out of wedlock is omitted. Later, after the child has acquired a legal name through usage, if he needs his birth record, proof of his name can be presented and the correct name can then be placed on the record. These simple solutions to the name problem, or variations of them, could be adopted under existing laws in practically all the States.

The foregoing suggestions are not the ultimate solution in birth registration. They represent only what appear to be the best methods of protection yet developed. Even now there is a changing concept in registration. Georgia is testing an entirely new method of birth recording. In this State the father or mother, rather than the attendant, prepares and signs the birth certificate. This and other experiments taking place may in a few years lead to eliminating the need for some of the safeguards now considered essential.

Social-work function of the vital-records office

Given the framework of adequate birth-recording procedures, there still remains the question of how and by whom the procedures should be interpreted to the person of illegitimate birth.

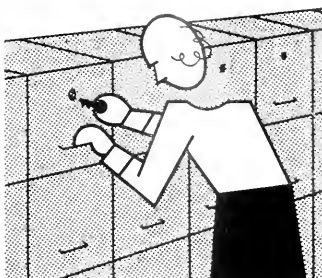
When the teen-age youngster needs a

BIRTH RECORDS SHOULD PROTECT A CHILD OF ILLEGITIMATE BIRTH

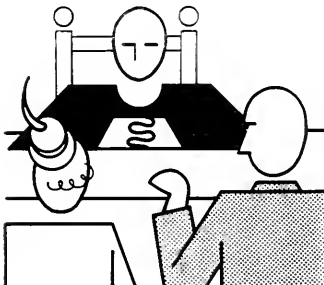
As the first step in protecting the child's legal rights a birth certificate should be filled out soon after he is born, with complete, accurate information, and sent immediately to the vital-records office.



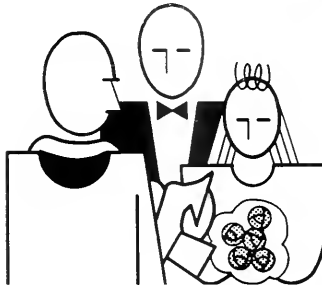
Most States keep under lock and key the original birth certificates of children born out of wedlock, and also all adoption records. The original certificates of all children should likewise be kept confidential.



Parentage can be proved in order to assure a legal right without a full copy of the certificate. In most States the registrar will send, to an authorized agency confidential verification of any item on the certificate.



When a child is adopted the court issuing the final decree of adoption should notify the State registrar so that a new birth certificate can be made and filed with the original as a permanent record.



When a child's birth is legitimated by the intermarriage of his parents, they should notify the vital-records office. The registrar will bring the record up to date, making a new certificate to be kept with the original one.



A birth card, which gives the child's name, sex, date and place of birth, and the number of his complete birth certificate, provides him with sufficient information for such ordinary uses as getting a work permit.

birth certificate to present to the local draft board, to obtain a work permit, or to get a job, he may have to face the truth for the first time.

In attempting to solve the problem of youngsters like Johnny Doe, whom we came upon earlier, asking for his birth certificate, some registrars have adopted such procedures as routinely issuing a partial copy of the original record without giving any explanation. Others try to obtain the name of a parent or guardian to find out whether the child has been adopted or legitimated so that the record can be corrected before he is given a copy. Some registrars, however, do not realize what it might mean to a teen-age youngster to learn that he was born out of wedlock. In such an office

the boy may be told bluntly, "You have no father."

In addition to seeking copies of their birth records, many persons born out of wedlock seek to learn their identity and family background from the birth record.

A youth who has an established relationship with a social agency can take his questions about identity to the agency. But 100,000 births out of wedlock take place each year, and many thousands of these people are never known to a case-work agency. Their questions of "Who am I?" must be handled by the personnel in the vital-records office, and the method of handling them depends upon the skill of the individual clerk.

The vital-records office is involved in adoptions and legitimations. And it has intimate contact with the large group of persons born out of wedlock whose status remains unchanged. In setting up and carrying out adequate standards for doing this job, registrars need help and support from groups of people in the community who are interested in improving the status of children born out of wedlock. Through this cooperation the registrars and the community groups may work toward protection not only for the records of the children, but for the children themselves.

Condensed from paper given May 23, 1946, at the National Conference of Social Work, Buffalo, N. Y.

Reprints available on request

CONGRESS GIVES "GO" SIGN TO SCHOOL LUNCHES

MARGARET M. MORRIS

*Production and Marketing Administration
U. S. Department of Agriculture*

WHEN PRESIDENT TRUMAN signed the National School Lunch Act on June 4, 1946, he put his name to a measure of national security planned by the Congress to safeguard the health of our children and to encourage domestic consumption of the products of our farms. This program has been carried out on a temporary basis since 1935, first in a period of depression and then continued as a wartime need. Now permanent legislation guarantees that the Federal Government will provide assistance in the "establishment, maintenance, operation, and expansion of nonprofit school-lunch programs." The appropriation for the fiscal year 1946-47 is 75 million dollars, of which the sum of 10 million dollars is earmarked for equipment.

The program will be administered by the United States Department of Agriculture. Funds will be given to the States as grants-in-aid. (Besides the 48 States, the District of Columbia, Alaska, Hawaii, Puerto Rico, and the Virgin Islands are included.) Apportionment will be according to the number of children between the ages of 5 and 17, inclusive, in the State, and the per capita income of the State as related to that of the United States. The act provides that the funds apportioned to a State are to be disbursed by the State department of education unless that department is prohibited by law from doing so. In that case the Governor may designate another State agency.

Both public and nonprofit private schools are eligible to participate in the program. No child-caring institutions are eligible except those operating schools. And child-care centers are not included in the programs except those

in Puerto Rico that are certified by the Governor as nonprofit.

The State agency will handle contracts with all schools in the State unless it is not permitted by law to disburse funds for private schools. In that case the U. S. Department of Agriculture, through its State office of production and marketing administration, will deal directly with the private schools.

The money provided by the Federal Government must be matched dollar for dollar from State sources until June 30, 1950. After that, until June 30, 1955, \$1.50 from within the State must match every \$1 from the Government. Thereafter every Federal dollar must be matched by \$3 from within the State. For matching, payments by pupils, contributions, and income from any other source may be used. And a reasonable value may be put on volunteer services and donated goods other than commodities given by the Government.

Schools that enter into an agreement to obtain Federal assistance must make the same lunch available to all children enrolled, regardless of their ability to pay, and without discrimination. Emphasis is placed on the serving of a complete meal, known as the type-A lunch. This lunch consists of a selection of foods designed to provide one-third to one-half of the growing child's daily nutritive requirements. The maximum reimbursement for this lunch is 9 cents. Some schools may decide to serve the type-B lunch, which is less

adequate but is satisfactory to serve when it is supplemented by food brought from home. The maximum reimbursement for the type-B lunch is 6 cents. Schools with no facilities for serving lunch may receive Federal aid in providing $\frac{1}{2}$ pint of milk a day for each child. The reimbursement is 2 cents.

Food is purchased locally by a representative of the sponsor of the program and a claim submitted monthly to the Government for the amount due. At the same time a brief report of operations is made in accordance with the requirements of the law. The school may also receive food which has been purchased directly by the Government. The school may request these foods, whether or not it is participating in the reimbursement part of the program.

Schools desiring aid in buying equipment for storing, preparing, or serving food should apply to the State agency. In order that reimbursement may be made for the cost of equipment the purchase must be first approved by the State agency.

The new legislation gives the "go" signal for improved programs throughout the country—better lunches for more children. Approximately 8 million children benefited from federally aided lunches in the past fiscal year, and there is no reason why this number cannot be exceeded in the coming year. Every child who eats nutritious lunches at school this year will be a potentially healthier citizen in the years ahead.

Frank and Ed are enjoying hot lunch at school. Today they have an egg, cheese, potatoes, and black-eyed peas, as well as a tangerine and $\frac{1}{2}$ pint of milk. Like millions of other school children in the United States they receive a nutritious midday meal daily under the National School Lunch Program. Schools reimbursed for these meals by the U. S. Department of Agriculture under the program agree to offer lunch to all the pupils in the school whether or not they can afford to pay.



TAKE STOCK OF CHILD-WELFARE SERVICES

MILDRED ARNOLD, *Director, Social Service Division, U. S. Children's Bureau*

NOW that the war is over, what should be the peacetime responsibility of public welfare agencies, especially with regard to children? And how should these agencies gear themselves to assume those responsibilities adequately?

Before discussing the special needs of children, let us look at the stages of development in public welfare services in this country and see how far we have come in the concept of public responsibility for the well-being of people.

The concept of public responsibility for the social, as well as the economic, well-being of people has emerged slowly. For many decades the main responsibility for meeting the economic needs of people was left with the private agencies. These private agencies, though well meaning, could provide only meager aid, with scant coverage. The depression fixed firmly in the minds of the people that government had a responsibility for the basic maintenance of people who were without means of their own. Thus, prior to the passage of the Social Security Act, government's responsibility rested mainly in meeting the basic economic needs of individuals and families.

Responsibility for services to children outside family groups was also seen as that of meeting maintenance cost in institutions or foster-family homes. Where government assumed this responsibility it was a State or local government, and this was by no means universal.

The Social Security Act placed a continuing responsibility on the Federal Government to assist the States and localities in meeting basic economic needs of special groups of people who, because of certain circumstances, were unlikely to be able to meet their own needs. It also assured these people that such assistance would be available, under certain circumstances, regardless of where

they resided within the State. Immediately after State passed public-welfare acts in order to enter into partnership with the Federal Government in assuming this public responsibility.

The idea also filtered into the Social Security Act that perhaps public responsibility went beyond the mere meeting of economic needs of people. In one place in the act the term "public welfare services" is used. This phrase is followed immediately by the statement that from then on these will be referred to as "child-welfare services"; they do not, therefore, refer to all the service aspects of a public-welfare program.

No specific definition of child-welfare services is given. The act states in broad terms what groups of children are to be served—the homeless, the dependent, the neglected, and those in danger of becoming delinquent. Significantly, it points to the need for community organization as well as for services to individual children.

Many of the State public-welfare acts follow this same pattern. Others have had broader acts, or their public-welfare act is supplemented by old acts on the statute books which make broader services possible, particularly in the field of child welfare.

The States, the local communities, and the Federal Government have been working together now for 10 years under this type of legislation. During this decade there has been developing a philosophy that public responsibility goes far beyond meeting the economic needs of people. Starting first with a recognition of the needs of special groups of children, it is now beginning to take the form of recognition of the need for social services for all people in need of such services.

Tangible evidence of this recognition is found in recent bills introduced in Congress. One bill states clearly the need for guidance and social services



Buddy is alone in the world, and a social worker is taking him to a new home. Such service needs careful planning if the child's life is not to be scarred too deeply. In this country over 4,500,000 children under 18 have lost one or both parents by death, divorce, separation, or desertion.

to children. It attempts to define more clearly what is meant by child-welfare services and emphasizes the importance of having these services universally available. Another bill more recently introduced provides for public-welfare services to all people in need of such services. This bill also uses the term "social services."

In the light of these developments there is an urgent need, now, to analyze, define, and identify special services within the framework of a total public welfare program. This needs to be done in all areas of public social service.

We have been talking for a long time in broad terms as far as services are concerned and in large categories as far as clients are concerned. We have talked about family-welfare services and child-welfare services; about services to children in their own homes and to children outside their own homes; about such large categories as families,

the aged, and children who are dependent, neglected, delinquent, or handicapped. The public-welfare agency of the future appears to be destined to serve all these groups in varying situations. There is urgent need now to analyze services more carefully and to see what they involve in terms of problems and needs. We must define and identify the services to determine the special skills and techniques required.

I will discuss a few of the areas that need this consideration as they relate to the special needs of children.

Probably there is no area that presents more serious problems, or calls for greater skills on the part of workers, than services to children who are neglected or abused by their parents or legal guardians. Protective work is one of the oldest forms of services in this country. It started in 1875, when the first Society for the Prevention of Cruelty to Children was organized. Although services in this field were started under private auspices, gradually they have been recognized as not primarily the function of the private field. Consequently they have been made a part of public welfare services in many States. The Social Security Act, as well as many State public-welfare acts, lists neglected children as one group to receive services.

Protective services represent the agency's concern for the welfare of children, as well as the community's. Since this protection should be avail-

able to all children who are neglected or abused, regardless of where they live, it becomes the rightful function of public social services.

This field is fraught with controversies at the present time, but this very fact points out more clearly the need for analyzing and defining the services.

What analysis should include

Analysis of the services should include careful study of the referral-and-intake process, since the complaint or request comes from someone other than the person responsible for the care of the child. There must be careful consideration of the authority by which an agency steps in to try to change or modify the child's situation. The staff must understand the full scope of action to which the agency is committed in safeguarding the children. Careful attention should be given to the matter of full participation of the family in the process. Responsibility for working with the person making the complaint must be carefully thought out.

Because these services represent the community's concern for its children, the agency needs to consider in what ways it can effectively represent the community. Since other community agencies are usually involved, the responsibility of the public-welfare agency must be clearly defined and its relationship to other agencies in this area clarified. There should be consideration of the techniques to be used in

approaching and working with the child's family.

I wonder how many of the public-welfare agencies in the country, who are attempting to give some services to children who are neglected or abused, have subjected their services to this kind of analysis and have prepared standards and procedures for the guidance of the staff. This has not been done for the most part in many of the manuals and much of the other material that has come to my attention.

Another area needing this type of analysis and identification is that of services to children whose mothers are working.

The war taught us many things about day care. It is a service which represents, perhaps more than some of the other services, community problems involving education, health, social work, recreation, labor, and industry. Because this is true it is highly important that the role of social work in this kind of service be delineated and defined.

Many of the parents and children served have had no previous contact with social-work agencies. In meeting the particular needs of these people, skills from many areas are drawn upon, such as child welfare, family welfare, group work, child development, nursery-school education, and recreation. We find that foster-family day care is not entirely comparable to 24-hour foster-family care and that it often fails to meet people's needs when it

Neglected children, if home conditions are not corrected, need to be cared for away from home, and 225,000 dependent and neglected children are in foster homes or institutions. Tens of thousands of others need such care, but facilities are lacking.



Every year 25,000 runaways come before juvenile courts. Many might have stayed home, out of trouble, if their parents had recognized early behavior problems. We have made only a small beginning in understanding and dealing with such problems.



Police pick-up a million youngsters like these each year. To keep such boys from becoming delinquent, public welfare departments need to work with the police and other community resources. This is a responsibility that such a department must assume.



is merely attached to an already operating foster-care program. We have learned that group care to meet the needs of some of these families differs greatly from institutional care. Even before the war, when attempts were made to combine 24-hour care with day care, these attempts usually ended in miserable failure. We have discovered that to be really successful this service must have an identity of its own. It is through this identity that we can see the special problems presented and the special skills and facilities needed.

I wonder how many agencies, the country over, took the war period as an opportunity to examine and define the need for services to children of working mothers and to develop standards and skills in this area. This demand, though greatly accentuated by the war, has been with us for a long time and promises to carry over in the post-war period. Perhaps these services will point out, more clearly even than other social services do, that we are entering a new era in social welfare that will be marked by an extension of services into economic groups and areas of community life where social work has not entered before in any fundamental sense.

One area that requires careful analysis and that cuts across practically all services in the public welfare agency is the intricate problem of family relationships. That it is a serious and mounting problem is evidenced by the

fact that divorce rates have risen steadily in this country for at least half a century—rising at accelerating rates immediately after the end of wars. It is believed that more than one out of every five marriages ends in the divorce courts. The unhappy family conditions that lead to these divorces are most disastrous for the children.

Consider the whole family

We have never even scratched the surface, in either family or child-welfare service, of this complicated matter of family relationships. Too often, when service to the family is given, the individual members do not stand out in clear focus. On the other hand, child-welfare services are apt to concentrate too much attention on the problems of individual children and do not define clearly, or deal effectively with, the relationships within the family that are mainly responsible for the children's problems. It is necessary constantly to keep in mind that children do not live in isolation. They are a part of the family, and consequently public welfare services must serve the whole family.

In one community recently the council of social agencies developed a counseling service in an effort to find out what the problems in the community were and how they could be met. The majority of the persons seeking counseling service were not asking for services from a social agency; yet it was found that many of the requests should and

could be referred to ~~some agency~~. Significantly, 72 percent of the requests for placement of children involved deep emotional problems of family relationships and indicated that other members of the family, as well as the children, needed help. If public welfare agencies are to assume, in the postwar era, the role of providing social services to people regardless of their economic status, will these agencies be equipped to deal effectively with complicated problems of family relationships?

Another area which needs closer examination and analysis is that of detention care. About all we have learned from the war experience in this area is that thousands of children are kept in jail. Will the present drive in many States for bigger and better detention homes really meet the needs of these children? How does the use of foster homes for this type of care differ from the use of such homes for longer-time care? Have the States and communities developed criteria for the care of children awaiting court hearing?

The whole area of temporary shelter and emergency care requires careful analysis. Too often all children needing short-time care—whether they are delinquent and waiting court hearing, dependent and temporarily without a home, or neglected and needing immediate placement pending more adequate plans—are thrown together into this type of care with no real consideration of their individual needs, with staff un-

At least 34 States hold children in jails—sometimes for weeks or months—while they are awaiting court hearings or because they must be detained for other reasons. They are kept in jails because proper facilities for detaining children are not available.

Like tens of thousands of others, these two children have no place to go; their city has closed its day-care centers. The centers formerly provided social services and other services to help working mothers and their children solve their problems.

Even such a family as this may meet crises that make the parents feel the need of social service. Public welfare agencies that may be called upon for such services should be equipped to deal effectively with the problems of family relationships.



prepared to cope with all the different situations involved, and with inadequate facilities for separation of the various groups. In two large communities, at the present time, plans are under way for the construction of large institutions which would throw together these various types of cases. And in addition, in one community, there is to be the added function of so-called "study" of children, pending long-term plans. One wonders how much real study can come out of a situation such as that.

Temporary shelter and emergency care of dependent and neglected children should be distinguished from detention care as well as from institutional and other types of care for treatment purposes. Although the number of children needing shelter and emergency care may be small in a given community, the traumatic experience which a child goes through in a sudden removal from his home and familiar surroundings warrants careful examination and identification of this type of service.

We should keep up with the times.

We have only made a small beginning in understanding and dealing with the behavior problems of children. Psychiatry is constantly throwing light on this area of service. We must keep abreast of new findings and be prepared to adjust our programs and develop new skills accordingly. An illustration of this was brought out at the meeting of the American Orthopsychiatric Association held this year in New York. It was stated that recent studies indicated that most gang leaders have been rejected by their mothers and in turn reject their mothers. A few experiments have shown that the most successful work with such men can be done by women social workers. This may result in radical changes from our past method of using men in such work.

We have made only a slight beginning in understanding the early deprivations in the background of the unmarried mother, the meaning to her of a succession of rejections, the loss of social status, and the lack of emotional support from the father of the child.

Many other areas also should be carefully analyzed and defined. Each needs to be given its own identity—such as the services to children in migratory families, to children in minority groups,

to children affected by the long-time absence of parents, to children who have physical or mental disabilities. This same analysis and identification are needed in the other services outside the child-welfare field.

An analysis of services to children should make a real contribution to the other areas in a public welfare program, such as services to the aged. An article by John J. Griffin in the December 1945 issue of the *Social Service Review* on "The Growing Problem of the Aged," points this out in relation to services to the aged. He states that leaders in this field must undertake some extensive self-education and the systematic training of staffs in an awareness of the specialized demands of the aged—that guidance to the aged is as necessary as guidance to children and that the aged require the same highly individualized treatment.

We hear much these days about coordination and integration of services. It is necessary that there be such coordination and integration within an agency serving such large groups with such differing problems and needs. Integration does not come about, however, by simply throwing together a lot of unknowns. It can come about safely and soundly after all the services have been carefully analyzed and defined.

Then there can be more adequate use made of the different skills of staff members, supervision can be more effectively planned, budgeting can be realistic, and statistics can be more meaningful.

When the Children's Bureau changed its statistical procedure in child-welfare services 2 years ago so as to count the total number of children receiving such services, it became apparent again and again that there was great value in analysis of these services.

Interpretation of the programs can be much more effective in the future if services can be made real and graphic. A State auditor recently said that he thought there were tangible things the child-welfare division did, which the legislators could understand. He had noticed that they could understand foster care and adoption, but that it seemed difficult for them to appreciate the work of the division in fulfilling the needs of children in their own homes.

With this analysis of services, staff development and in-service training

programs will go beyond the so-called generic approach and will really be planned to develop the various skills needed in a many-sided program. There can be much effective working with merit-system councils in the recruitment, selection, placement, and evaluation of staff.

I wish to reemphasize the need to define all special services in the field of public welfare. The less you define these the more you water down the services. Salaries are depressed and staff is given no opportunity either to develop or to use special skills and techniques.

Summarizing.

In summary I would like to stress five points:

1. There is a great need in this country for a universal program of public social services for all people in need of such services.
2. Any tendency to separate off, to isolate, to "pocket," any of the services in the program is unsound.
3. There must, however, be a strong conviction on the part of those responsible for such services that there are distinct and special needs in the different groups of people to be served.
4. Services to meet these special needs must, therefore, be more fully analyzed, defined, and identified in order that special skills and techniques can be developed and that there may be more effective use of staff.
5. When this is done, constructive coordination and integration of services into a composite whole within the total program is possible.

A recent statement of the National Commission on Children in Wartime may well serve as a guide to all of us at this strategic time in the development of public social services in this country: "Let us resolve now for the peace that is ahead, that we will build courageously, imaginatively, ungrudgingly, and without discrimination as to race, color, creed, or national origin, services which will reach out to all our children and youth wherever they live and whoever their parents may be. Our greatest chance for a lasting peace lies not with us but with them."

Presented at the southeastern regional conference of the American Welfare Association, Columbia, S. C., April 5, 1946.

Reprints available on request

HAZARDOUS OCCUPATIONS

ORDER NO. 7 ISSUED

A NEW hazardous-occupations order was issued early in July by the Chief of the Children's Bureau, declaring that work on power-driven hoisting apparatus is particularly hazardous for young people under 18.

When this order goes into effect, September 1, 1946, it will have the effect of prohibiting employment of workers under 18 on this type of apparatus in all establishments covered by the child-labor provisions of the Fair Labor Standards Act of 1938; that is, to any producer, manufacturer, or dealer who ships or delivers goods for shipment in interstate commerce.

Freight and passenger elevators, cranes, hoists, and derricks, are included in the apparatus covered in the new order, as well as high-lift trucks, a type of hoisting device that was widely used during the war in military depots, and is being increasingly used in manufacturing establishments. Not only the work of actually operating such apparatus is specified in the order as particularly hazardous, but also other work that involves riding on freight elevators, and certain kinds of work in assisting in the operation of other hoisting apparatus.

This order, the first issued since early in the war period, is based upon an investigation of hazards to workers on various types of power-driven hoisting apparatus. This investigation, made by the Industrial Division of the Children's Bureau, was begun shortly after the end of the war.

In making the investigation, the Industrial Division staff studied accident reports of several State labor departments and of three Departments of the United States Government—Labor, War, and Navy—and compiled what statistical evidence was available and pertinent. They also analyzed State child-labor laws and regulations to find

out the extent to which States have established a minimum age for workers operating specific types of hoisting apparatus, and they drew upon the experience and opinions of safety engineers, employers, and workers.

The report of the investigation shows that—

1. Many minors under 18 years of age are being injured in operating or assisting in the operation of hoisting apparatus.
2. The number of industrial injuries caused by hoisting apparatus is substantial in comparison with industrial injuries in general.
3. Injuries due to hoisting apparatus are relatively severe, resulting in a disproportionately high number of deaths and permanent disabling injuries.
4. Injuries due to hoisting apparatus occur not only to the operators but

also to those assisting in the operation of hoisting apparatus and to other employees.

5. The hazards of operating or assisting in the operation of hoisting apparatus tend to be greater for young persons than for more mature persons because young persons usually lack the characteristics of caution and judgment needed to operate hoisting apparatus safely.
6. The hazards to minors of operating hoisting apparatus are recognized by minimum-age standards for the employment of young workers imposed by State laws, and in nationally recommended safety codes.

A public hearing was held June 25, 1946, at which representatives of management, labor, and other groups appeared in support of the proposed finding and order or to suggest certain revisions.

Two reports of accidents, taken at random from newspaper reports, will illustrate some of the dangers from which the order seeks to protect boys and girls of 16 and 17. (The reports are briefed from the *Boston Traveler*, April 8, 1943, and the *Chicago Sun*, October 18, 1944.)

Francis W., 16 years old, had been employed 3 months as an elevator operator in an industrial plant when he was killed—crushed to death by an elevator. When his body was extricated by the fire department the medical examiner pronounced him dead.

A 16-year-old messenger boy for a manufacturing company (not employed as elevator operator) was killed while operating a freight elevator at the factory. He apparently was caught between the third and fourth floors of the building.

The order concerning power-driven hoisting apparatus is the seventh hazardous-occupations order that has been issued since the Fair Labor Standards Act of 1938 went into effect. The first one, effective July 1, 1939, concerns manufacturing of explosives. Others relate to motor-vehicle drivers and helpers, the coal-mining industry, the logging and sawmilling industries, power-driven wood working machinery, and radioactive substances.



This is the kind of thing that makes operating an elevator an extremely hazardous job. The gate is stuck, and the boy is trying to close it. If he should slip and fall, and the gate should drop, he might be badly injured.

Careers in nursing

"Nursing Offers You a Career Now" is the title of an attractively illustrated folder issued by the National Nursing Council as part of a campaign to stimulate qualified young women to enter nursing schools this fall.

Many a qualified girl who vaguely "would like to be a nurse" will be impelled to do something about it at once when she reads in this folder about the challenging opportunities that a nurse may choose from—such as work in hospitals, in public health, in the Federal services, in industry, in teaching, in orthopedics, in tuberculosis nursing, or in psychiatric nursing.

Take, for example, a career in public-health-nursing.

Says the folder: "Approximately 20,000 public-health nurses, many of whom have special preparation besides a basic nursing education, are now working in the United States. It is estimated 40,000 more are needed. The public-health nurse often gives direct care to the sick, but her chief function is to keep people well. Whether in helping to trace the source of an epidemic, or in instructing a class of mothers in wise care of their children and themselves, she is a valiant fighter in the cause for a healthier America. She carries the gospel of better health into homes, schools, factories, clinics, and public meetings. The public-health nurse often becomes a community leader of first rank."

Practical questions such as "How Much Can You Earn?" are brought up. More complete answers to this question are given in a leaflet published by the same council, "Opportunities in Nursing," which gives a table showing the latest salary ranges for nurses in different types of positions.

"What Does a Nursing Education Cost?" is a serious question for many girls who would like to be nurses. The folder suggests that a girl who needs financial help in getting a nursing education should mention this fact when writing to the director of the school she wishes to enter.

Also, the folder reminds both men

and women veterans that those eligible to enter a school of nursing may apply their educational benefits under the G. I. Bill of Rights to this type of school.

The drive to tell young women of the advantages of a nursing career, of which this folder is a part, is being carried on by the National Nursing Council in an effort to meet the present serious shortage of nurses. The council urges clubwomen and other persons interested in a healthier America to join in this drive.

Write to the National Nursing Council, 1790 Broadway, New York 19, N. Y., for copies of "Nursing Offers You a Career Now"; also for a fact sheet that can be used in spreading information about the need for nurses and the advantages in entering the nursing profession.

To guide voluntary agencies working for children in Europe and Asia

Out of a deep concern for the immediate and future goals of the total child-welfare program abroad, the agencies represented on the child-welfare committee of the American Council for Voluntary Agencies for Foreign Service have issued a statement of principles for the guidance of voluntary agencies working for the suffering children of Europe and Asia.

The agencies make this statement on the basis of their experience in relief to children in many areas of the world. In doing so, the agencies are fully aware, from their first-hand contacts with these problems, that there is a priority of needs that must be met, that famine and hunger must be dealt with swiftly and effectively.

The council is an organization of about 60 voluntary agencies, which has as its purpose the same objective as each of the member agencies—the maximum use of the contributions made by the American people for the relief and rehabilitation of people overseas. The council provides a medium through which the voluntary agencies together

plan programs to achieve that end. It tries to eliminate duplication of effort and promotes effective consultation and cooperation not only among its member agencies, but also with other private agencies and with governmental and intergovernmental bodies at home and abroad.

The committee on child welfare is one of a number of functional committees of the council that deal with special branches of the work of relief and rehabilitation, such as the committee on cooperatives, the committee on displaced persons, and the committee on material aid.

The council also works through area committees and subcommittees, such as the committee on the Balkans, with subcommittees on Greece and Yugoslavia; the committee on France; and the committee on the Orient, with subcommittees on China, India, and Netherlands East Indies.

The child-welfare committee has recommended the following principles for the guidance of member agencies and of any other agencies engaged in child-welfare work abroad that are interested in improving their services.

1. Role of voluntary agencies

Where the individual is unable to provide the basic needs of food, clothing, shelter, education, and medical care for himself and for his family then it is the responsibility of governmental or intergovernmental agencies to provide these needs.

However, when governmental or intergovernmental agencies cannot bear this responsibility, it may be carried by voluntary agencies to the best of their abilities until such time as the Government can assume this responsibility.

Voluntary agencies have the responsibility and the right, whenever necessary, to supplement basic programs for children to the full extent of their resources and to undertake additional services designed to help in the normal growth and development of the child.

American voluntary agencies should foster the independent functioning of indigenous voluntary agencies through training of workers and other methods of developing independent services.

American voluntary agencies, in this process, may provide direct services, funds, experienced workers and equip-

ment where local agencies are not able to do so.

2. Emergency care

All mass planning, including mass-feeding for children, should be considered only as temporary emergency measures to be eliminated at the earliest possible moment.

During the period of emergency care, the principles enunciated below should, wherever possible, be incorporated into the temporary programs.

3. Basic needs

It is not enough to meet basic physical needs of children without simultaneously attempting to meet emotional, educational, and spiritual needs.

4. Family life and institutional care

Every effort should be made to restore family life, recognizing that one of the most serious barriers to this is the continued enforced separation of heads of families from their children.

In general the child is best cared for by his parents or by the immediate survivors of his family.

However, care in properly organized and staffed institutions can be the most constructive solution in instances where foster homes are inadequate or inappropriate or there is need for a period of preparation for a new setting.

5. Continuity of relationships

Continuity of relationships and experiences in a secure setting are fundamental to the normal development of children.

Inasmuch as forced migrations of millions of people violate this principle, the agencies concerned with child welfare can only deplore the fact that such forced migrations are a feature of the peace.

Where there are children still in an insecure and temporary setting, every effort should be made to resettle them as speedily as possible in security and permanence before lasting harm is done to them.

6. Planning for the future

The plans of many new groups of Americans of good will to aid children in the war-devastated lands are opening up new resources to meet those unprecedented needs.

Unless such plans are integrated with those of established agencies who have been operating in accordance with approved standards, they may lead to as much confusion and harm as good in the field of child welfare.

July 15, 1946

State committees on children and youth

FLORIDA

The Florida Children's Committee has been appointed by the Governor, and it held its first meeting July 1. The committee includes 18 members, representing most of the large groups in Florida interested in children. Mrs. Ellen Whiteside of Miami is serving as chairman.

As a result of recommendations made in March by a State-wide conference on juvenile delinquency, the Governor has appointed a committee, to be concerned not only with the treatment of individual juvenile delinquents but also with long-range planning for the prevention of juvenile delinquency.

The committee, for its work with children and youth, has set objectives that include knowing what is happening to children and youth, reviewing legislation, appraising the services available, consulting the various agencies serving youth, drawing up proposals for action, reporting findings to the public, maintaining contact with State and local agencies, and recommending constructive programs for children and youth. The committee is asking the Governor to appoint, in each of the 67 counties, a committee whose responsibility primarily will be in the field of juvenile delinquency and secondarily will deal with county planning to determine children's needs.

KANSAS

The Kansas State Board of Health News Letter for May 1946 says:

"Health for Kansas children held the spotlight in the all-day meeting Saturday, May 18, of the Kansas Council for Children. The meeting was held at the Hotel Kansan, Topeka, with the vice-chairman, Mrs. Albert Kuslner, and Paul R. Ensign, M. D., secretary, pre-

siding in the absence of the chairman, Dr. John B. Geisel.

"The council decided to serve as a public-relations committee for the recently launched national survey by the American Academy of Pediatrics, in which Kansas is cooperating. This survey, endorsed by the Kansas branch of the Academy, the Kansas Medical Society, and the Kansas State Dental Society, will be assisted by the Kansas State Board of Health in summarizing facilities and needs for maternal and child health in every community, in the fields of medical, hospital, and community health organization. Dr. E. C. Padfield, Salina, reported on the plans for Kansas, and told of the pilot study completed in North Carolina."

The council endorsed the plan for a demonstration in Cowley County, beginning in July, following recommendations made in a recent school and community health study in Kansas, conducted by the State Department of Education and the State Board of Health.

MARYLAND

Donald I. Minnegan has been named as acting director of the Maryland State-wide Commission on Youth Services.

MICHIGAN—KENT COUNTY

The May issue of Youth Guidance in Michigan reports that the Kent County (Grand Rapids) Youth Guidance Committee has developed a broad program of action for the youth of the county. Among the activities are the following:

Children's worker.—Requested from the State Department of Social Welfare the services of a children's worker for Kent County.

Teachers' institute.—Planned an institute to assist teachers in recognizing early behavior symptoms of maladjustment in children.

Juvenile-detention home.—Appointed a subcommittee to survey the needs of the juvenile-detention home, to encourage the purchase of recreational equipment by the Junior League of Kent County, and to plan further improvements.

Foster homes.—Sponsored an extensive campaign to acquire good foster homes for children; instituted a series of lectures on the subject of foster homes.

Juvenile bureau.—Adopted a resolution requesting the police department of Grand Rapids to establish a bureau for prevention of juvenile delinquency, with personnel qualified to handle children's cases within the police department.

County welfare agent.—Recommended to the Kent County Judge of Probate that a qualified social worker be employed as county welfare agent.

Probate judge.—Recommended that an administrative assistant to the Probate Judge be appointed to assume supervision of all juvenile cases.

Juvenile court.—Recommended that the physical set-up of the juvenile-court rooms and offices be remodeled in an effort to provide the best service in appropriate surroundings.

Charter amendment.—Took an active part in attempting to obtain a charter amendment increasing the tax millage in the interest of increasing educational facilities and protection for children and youth.

MINNESOTA

On May 9, the Governor appointed an Advisory Committee on Youth, of which the Rev. Joseph C. Simonson is chairman and Jarle Leirfallom is secretary. The Governor has given the committee freedom to plan its own activities and proceed as it thinks best. One member of the committee is a 16-year-old St. Paul high-school boy, who was recommended for membership at a Hi-Y meeting held in April by a local Y. M. C. A. and Macalester College.

NEW JERSEY

An advisory committee on community services for delinquency prevention has been appointed in New Jersey, with Mrs. Samuel I. Kessler as chairman, to advise the division of community services for delinquency prevention (Douglas H. MacNeil, director) in the State Department of Institutions and Agencies.

The advisory committee includes 22 citizens, forming panels on various relationships—educational, judicial and law-enforcement, social-agency, youth-group, and civic-organization—and an interdepartmental panel including the State commissioners of education, health, labor, and economic development and the superintendent of State

police. The State commissioner of institutions and agencies is a member of the coordinating committee, which includes the chairmen of the panels and the State officials. One of the responsibilities delegated to the division and the committee is the continuance of the work of the State child-care committee.

NEW YORK

The Committee on Child Care, Development, and Protection, which was appointed in 1942 under the State War Council, went out of existence on April 1, when its responsibilities were taken over by the State Youth Commission.

Edith Rockwood

Connecticut saves lives of mothers

From the Connecticut Health Bulletin, June 1946:

"It has been revealed from records in the [State] Bureau of Vital Statistics that the Connecticut maternal mortality rate for 1945 was 1.0 per 1,000 living births. This rate is the lowest ever recorded in Connecticut and has never been equaled by any other State. In actual numbers, there were 32 maternal deaths among 32,423 births. The maternal mortality rate in 1944 was 1.5. The rate of 1.0 in 1945 is a reduction of 33⅓ percent below the previous low of 1.5, the rate in 1944. This outstanding record was achieved through the combined efforts of physicians, nurses, and each expectant mother in the State."

Universities offer new courses for graduate nurses

Schools of nursing are giving more and more attention to the needs of mothers and children. Announcements from three universities describe the following courses:

Maternity nursing

In cooperation with the maternity division of the Pennsylvania Hospital, the University of Pennsylvania's department of nursing education is offering an 8-month course to prepare qualified graduate nurses to give expert nursing care and supervision to mothers and babies throughout the maternity cycle;

this course is planned to prepare nurses for the positions of head nurse, supervisor, and clinical instructor in maternity nursing.

For public-health nurses whose preparation and experience include the equivalent of the sections of the course related to community aspects of maternity nursing, some adaptation of the field experience would be made; this would reduce considerably the time spent by such nurses on the clinical content of the course.

The course begins in October 1946.

For further information write: Miss Katharine Tucker, Director, Department of Nursing Education, University of Pennsylvania, 3810 Walnut Street, Philadelphia 4, Pa.

Nursing care of premature infants

A 3-month supplementary program in the care of premature infants is offered by the Johns Hopkins Hospital School of nursing to a selected and limited number of qualified graduate nurses. Six points credit toward the bachelor of science degree is given for this work by the Johns Hopkins University College for Teachers.

For further information write to Miss Anna D. Wolf, R. N., Director, School of Nursing and Nursing Service, Johns Hopkins Hospital, Baltimore 5, Md.

Orthopedic, maternity, and pediatric nursing

To meet the great demand for teachers and supervisors of nursing, the Division of Nursing Education, Teachers College, Columbia University, has developed a series of advanced clinical courses in cooperation with hospitals, clinics, public-health-nursing agencies, and other social and health agencies. Among the subjects of these courses are: Orthopedic nursing (winter and spring sessions 1946-47); maternity nursing (spring session 1947); and pediatric nursing (winter and spring sessions 1946-47).

All these courses are open to graduate nurses who meet the requirements for admission to one of the major programs in nursing education, who have the necessary scientific and clinical foundations for advanced study in the clinical field selected, and who have demonstrated evidence of special interest and potential ability in that field.

INTRODUCTION TO EXCEPTIONAL CHILDREN, by Harry J. Baker, Ph. D. Macmillan Co., New York, 1945. 496 pp.

This book by the Director of the Psychological Clinic, Detroit Public Schools, is a welcome addition to the increasing body of literature dealing with the extent and treatment of physical handicap and mental deviation. Unlike many books on these subjects, this volume lives up to its title and is indeed an introduction to the children, describing the various types of handicaps and deviation from the normal, causes, symptoms, and characteristics, and discussing remedial or preventive measures. The term "exceptional" is used by the author to include children at both ends of various scales, and mentally gifted are included in the case of mental variations. This broad definition is adopted, the author says, in order to "bridge a gap between the normal, average child and the extremely handicapped or exceptional, and to interpret the needs of the mildly handicapped who are often more neglected and misunderstood than are those with more severe deviations." Not the least valuable of the contributions made by this book are the descriptions of methods of diagnoses and treatment afforded by various clinics and special schools in Detroit and other cities.

The book is addressed especially to college and university students and teachers, but it should also prove valuable for social workers and all others concerned with child development and the special problems of "exceptional" children.

Emma O. Lundberg

AFTER-CONDUCT OF DISCHARGED OFFENDERS, by Sheldon Glueck and Eleanor T. Glueck. English Studies in Criminal Science, vol. V. Edited for the Department of Criminal Science, Faculty of Law, University of Cambridge. Macmillan & Co., London, 1945. 114 pp.

This book is a report on what happened to 1,000 former prison inmates and 500 reformatory graduates during

three 5-year periods after their original release from the institutions. The information reveals that the correctional institution is of little value as a tool in the treatment of delinquency. Through this book we learn the primary causes of our high rate of recidivism and the ineffectiveness of our parole systems.

The authors stress the value of using scientific information gained through follow-up studies in the treatment of delinquents. They believe that for the vast majority of crime and criminals the "corrective theory," based on the conception of multiple causation, should predominate in both legislation and judicial administration. They believe further, that legally trained judges should act as impartial referees during technical trials heard by juries, but that the decision regarding treatment of the offender should be the responsibility of a board especially qualified in sociology, psychiatric, and psychology, as well as legal data. They see the views which they expressed many years ago embodied in the model draft bill for a youth correction authority.

The results of the Gluecks' scientific methods used in studies over the years have enabled them to compile interesting and valuable prognostic tables. Although further validation of the tables is necessary, the criteria contained therein will in the future enable judges and sentencing boards to select from the tables the proper treatment for delinquents with considerable assurance of success in change of behavior and attitude on the part of the offenders.

Frank F. Maloney

HOW CHILDREN DEVELOP; a revision of child-development study, by the faculty of the University School, University School Series No. 3, Ohio State University, Columbus, 1946. 79 pp.

Though this bulletin on child growth and development from infancy through adolescence is probably thought of as

being useful chiefly to school teachers and administrators, it should serve a far wider audience.

In outline form, under the headings Health, Security, Achievement, and Interests and appreciation, are thumbnail sketches of each of eight age periods, which actually come alive. We recognize, for example, the 6- to 9-year-olds of whom it is said "these children may take special delight in using unacceptable language, coming to the table with hands unwashed, preferring to wear their most tattered sweaters instead of their newest ones."

Anyone who deals with children will find himself dipping into these pages often to get freshened up on what kinds of behavior are significant at various ages, on what kinds are temporary, and on how boys and girls differ and how they are alike.

The understanding spirit of the findings and observations is emphasized by the lively cartoon illustrations done by a high-school junior. The up-to-date bibliography lists 81 items.

Marion L. Faegre

A BIBLIOGRAPHY OF INFANTILE PARALYSIS, edited by Morris Fishbein, M. D. J. P. Lippincott Company, Philadelphia, 1946. 672 pp. \$15.

This extensive bibliography, which was prepared under the direction of the National Foundation for Infantile Paralysis, was compiled by Ludvig Hektoen, M. D., and Ella M. Salmonsen. Beginning with a reference to a description of the disease included in Underwood's pediatric textbook published in England in 1789, the bibliography is arranged chronologically and includes material published through December 1944. A comprehensive index covering the references and articles by number greatly facilitates access to the various phases of the subject.

Workers in the crippled children's field desiring a comprehensive bibliography on the subject of infantile paralysis will find this volume invaluable.

A. L. Van Horn, M. D.

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The drawings on page 37 are by Philip Bonn.

A New Base for the Children's Bureau

July 1, 1946, marks the completion of 34 years of service by the Children's Bureau. Created by Act of April 9, 1912, the Children's Bureau was for most of its first year in the Department of Commerce and Labor. On March 4, 1913, the Bureau became a part of the newly created Department of Labor, charged with the responsibility of promoting the welfare of the wage-earners of the United States, and for 33 years the Bureau grew in influence and in responsibilities as a branch of that Department.

For many years the Bureau was the only branch of the Government giving special consideration to the health of mothers and children, and the only Federal agency concerned with problems and programs in what has come to be known as the field of social welfare. It played an important part in the movement leading to the authorization of funds for the relief of unemployment, and later in the development of the social-security program. It has done pioneer work in developing Federal-aid programs for medical and hospital care. It was developing relations with child-welfare leaders of the other American Republics more than 30 years ago, and with European leaders right after the first World War. Those

early experiences in international co-operation laid a foundation for the more specialized international activities in which the Bureau has engaged in recent years. The Bureau administered the first Federal child-labor law, 1917-18, and the first program of Federal aid to the States for maternal and child-health work, 1921-29.

Organized labor took an important part in the movement for the establishment of the Children's Bureau, and was in the forefront of the fight for a child-labor amendment to the Constitution. Relations between organized labor and the Bureau have always been close, especially so during the war years. The Bureau has benefited immeasurably from the leadership of the Department of Labor and from close association with the other branches of the Department.

With the expansion of the general health and social-security activities of the Government, there were many reasons for the closer association of the Children's Bureau with agencies responsible for these activities and with the educational services that are so intimately related to the programs of the Bureau. Accordingly, Reorganization Plan No. 2 of 1946, which became effective July 16, included transfer of the Bureau and its functions to the Federal Security Agency, except for the Industrial Division of the Children's Bureau

and the Bureau's functions relating to child-labor administration under the Fair Labor Standards Act.

The plan provided for the transfer of the functions of the Secretary of Labor and the Children's Bureau under title V of the Social Security Act to the Federal Security Administrator. By the terms of Agency and Administrative orders the Children's Bureau is placed in the Social Security Administration of the Federal Security Agency, where it continues to exercise all the functions for which it was previously responsible except for those left in the Department of Labor. By order of the Secretary of Labor the Industrial Division has been transferred as an organizational entity to the Division of Labor Standards, where it functions as the Child Labor and Youth Employment Branch of that Division. It will be necessary to maintain very close relations between that Branch of the Department of Labor and the Children's Bureau of the Federal Security Agency.

The increased funds for grants to States authorized by the recent amendments to the Social Security Act provide greater opportunity for the Children's Bureau, working with State agencies, to serve the children of our country.

Katharine F. Lenroot
Chief, Children's Bureau.

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FEDERAL SECURITY AGENCY
SOCIAL SECURITY ADMINISTRATION

CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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THE

SEPTEMBER 1945

CHILD



MENTAL-HEALTH SERVICES IN THE HEALTH-DEPARTMENT PROGRAM

KENT A. ZIMMERMAN, M. D., *Director, Mental Health Unit, U. S. Children's Bureau*

WITHIN the past decade statistical studies have brought out more clearly what we of the medical profession have suspected all along—that mental illness is a very prevalent disease. For example, one of these studies predicts that out of every 20 babies, one will spend some part of his life in a mental hospital.

That fact becomes alive and vivid if one imagines himself a teacher of a classroom of 40 pupils and realizes that the chances are that 2 pupils in that class will develop a serious emotional illness.

Few diseases, other than the common contagious diseases, affect such large numbers of people. And it has only recently been recognized that the distribution of mental illness in a community seems to have epidemic characteristics that are similar in a number of ways to those of contagious diseases.

We people of this country have done much to prevent other epidemic diseases. As individuals and communities, we agree to spend large sums of money for their prevention. We have not been willing to do as much to prevent mental illness. But whether we know it or not, each year we pay huge sums as taxes for the care of the full-blown mental illnesses of our neighbors.

Failure to do more to prevent mental illness does not rest entirely with us as individuals. Perhaps none of us is quite sure how best to spend money for prevention of mental illness. Perhaps we need to be shown that there are methods that we can understand and practice to prevent this kind of illness. Perhaps leaders and teachers in the field of mental disease have not been too specific as to what we should do. Without doubt, in many instances what they have recommended has been stubbornly resisted and is still being resisted.

The cry in the medical profession today is: "Where are the psychiatrists?

Give us more psychiatrists so that we can begin to solve this problem."

True, we need thousands of doctors trained in this specialty. The National Committee on Mental Hygiene conservatively estimates that we need 10,000 additional psychiatrists. But even though the psychiatrist is a key person in the situation, he does not have the complete answer. And the profession of psychiatry is risking its neck if it lets the people it serves sell it the bill of goods that psychiatry has all the answers.

We won't have 10,000 additional psychiatrists in 10 years—probably not in 15 years. Meanwhile we can't wait for them. Other professional workers—who haven't been trained in psychiatry—must realize that they can fill important posts in the battle to prevent mental illness. These workers—the doctor in his office or the clinic, the nurse in the home or the hospital, the social worker in the public or private agency—can do their share in preventing mental illness as part of their daily dealings with the people they serve. Especially are the workers of the health department of the State, county, and community in a position to do this.

We repeat childhood patterns

It is a fact accepted by those familiar with human behavior that the way adolescents and adults meet their problems of emotional adjustment seems to repeat the pattern of adjustment they followed during early childhood. General experience shows that efforts to prevent later mental illness are most effective when applied in this early period. This does not mean that efforts applied at later times in the person's growth are not effective. They are, as anyone who works with people knows.

There are two services that reach practically all children of the community. These are the school and the health services. A health department

that is responsible for the school health program can influence in some ways the life of almost every child in the community.

What are the services in a health department dealing with medical problems where mental-health problems might also be treated? Certainly the first one we think of is the well-baby clinic, or the child-health conference, as it is often called. In the well-baby clinic one meets problems of feeding, sleeping, and discipline and the like, which usually involve emotional as well as physical troubles.

Crises mark personality

Every child in his normal growth and development has to adjust to what are, for him, major emotional crises. These are, in general, weaning from the breast or bottle, toilet training, the arrival of a new baby in the family, and the beginning of school. Whether the adjustment is difficult or smooth, each of these crises will leave its mark on his growing personality.

It is about such problems that parents most often want to ask the most questions of the doctor, the nurse, and the social worker, and most often go away least satisfied.

When I was on the staff of a pediatric clinic I was impressed with how seldom mothers asked the doctors about toilet training. I talked with some mothers and learned that they felt the doctors couldn't help them much in this. The advice given by different doctors was often contradictory. Sometimes replies were curt. Frequently mothers were given the impression that it is not to a doctor that she should go for such advice.

"So," as one mother said, "I had to ask my mother and my next-door neighbor what to do."

Parents are constantly seeking such information and it is the seeking for this help that frequently reveals friction in

the relationship of the child and parent. This parent-child conflict is most commonly expressed as a complaint by the parent about the child. One mother told me: "I just can't understand what has come over Johnny. He seems to fight me every time I suggest that he eat all the food he has on his plate. Doctor, do you think that I am losing control of him?"

I might say that there is not a mother or a child who doesn't experience this friction, for it is inherent in the very nature of growing up that the child will

object to parents' interpreting and imposing upon him the behavior characteristics of the culture in which they live.

Take thumb sucking for an example. It is pretty well accepted that thumb sucking before the appearance of the second teeth does no permanent harm to jaws or teeth. With the current tendency for early bottle feeding, and training in the use of the cup, most babies will do some sucking other than at feedings simply because they have a need to suck that must be fulfilled. Yet granting the existence of this natural urge and its

need for satisfaction, most mothers and many doctors feel guilty if a child sucks his thumb. This is understandable because the social code under which we all live says that thumb sucking should be taboo. Poor parent-child relationship may arise from a problem such as this. I have seen a doctor make a mother feel so guilty about her child's thumb sucking that she began to form a resentment toward her child, because after that she felt that the child represented an inadequacy or failure on her part as a mother. The staff of a well-baby clinic



One fertile but neglected field for the promotion of mental health is the prenatal clinic.



Simple psychotherapy can help in many a problem met at a child-health conference.

Health examinations of school children are an opportunity for routine mental-health service.



Adolescents with venereal infection, troubled by guilt and fear, need sensitive help



should make efforts to guard against such situations so that a mother is not burdened with feelings of guilt and inferiority caused by fear that she isn't being the mother that she wants the neighbors and her husband to think she is.

The prenatal clinic is another fertile but neglected field for prevention of behavior disorders and the promotion of mental health. Pregnancy in any woman brings with it emotions of varying degree and kind—joy, satisfaction, well-being, physical misery, resentment, courage, and feelings that can't be put into words. The pregnant woman has fears and hopes not only about herself, but about her unborn child. These feelings often have a tremendous effect on her relationship to her child after he is born.

One mother, a fairly typical one, told me during the course of a routine well-baby check-up of her concern for her 2-year-old baby boy. An older brother of this woman had spent some time in a mental hospital and she feared that her baby might have in him the seed of mental illness. She had had this fear from the time she knew she was going to have a baby. It had tortured her through her period of pregnancy and she had been unable to throw it off after the child was born. As the baby grew, she began to watch his behavior intently. Every act of his that differed from what she had read about in well-baby books she saw as proof of what she feared. Even the normal resistance to her guidance that the ordinary child of his age shows disturbed her. The more he resisted her, the more fearful she became.

On several visits we discussed her brother's mental illness—its causes and the fact that it was of a nonhereditary nature. These talks were very reassuring to her. But she was comforted more by learning that her son's behavior was normal for his age and that her fears had made his actions more difficult for her to deal with.

Think what a great comfort it would have been if this woman could have discussed her fears at the time they began troubling her and how much easier it would have been for her child.

Especially does a pregnant woman feel a need to talk about her fears—to

be assured by some one she has confidence in. But most of the time she feels herself at a loss because she finds no professional person who will really listen to her or take her worries seriously.

Many obstetricians fail to recognize that the well-being of the pregnant woman is greatly helped if she can discuss anything she has on her mind. During the prenatal period the health-department doctors and, especially, the nurses of the prenatal clinic have a more than casual opportunity to practice simple psychotherapy. At that time the most elementary procedures can give the richest returns.

The well-baby clinic and the prenatal clinic are only two examples where such psychotherapy can be a part of routine service to patients. Others are the health examinations of school children, sex-education lectures to high-school students, and the premarital examinations that many health departments make.

Sensitive help needed

And there are still other areas of public health where preventive mental hygiene needs to become a part of treatment. Venereal-disease clinics offer a tremendous field. Adolescents with an initial venereal infection, who are troubled by guilt and by fear of the outcome of the disease, need sensitive help. A worker doesn't have to have psychiatric training to give this. What is needed is an inclination to give this help and a mature interest in people—plus a knowledge of proper methods of counseling that would prevent the worker from emotionally upsetting the patient all the more. Given the right kind of supervision and guidance, the doctor and nurse and social worker at these clinics—if not too overworked—should be able to do this if they want to.

The tuberculosis division of the health department has responsibility for the care of a physical disease that often carries with it deep emotional illness. Because of the chronic nature of tuberculosis, the forced isolation of the patient from family, friends, and community, his worries about the job and family support, it is no wonder that depressions and anxiety states frequently accompany this infection. Also in many public-health departments unsympathetic han-

dling of case finding and of X-ray checking after tuberculosis is cured often keep raw old psychological wounds. If wisely done, however, check-ups can be of tremendous psychological benefit. Workers in this field can grow to be more and more sensitive to the early signs of fear, worry, or chronic anxiety in the tuberculous patient. Often a few minutes' conversation with an understanding worker can reduce the resentment against what the patient feels is his fate. Quicker recovery follows and fears of recurrence of the infection are eased.

Changes come through struggle

How can doctors and nurses and social workers be taught this added method of treatment? Certainly lectures alone aren't the answer. Hundreds of nurses, social workers, and doctors have taken courses in child behavior and human psychology. Often from these courses they bring back to their daily practice nothing more than a new set of diagnostic terms—terms that represent no deep understanding of human beings.

Usually changes in a health or welfare worker's way of giving service come through struggle with the actual handling of the personalities involved in the medical and family problem. Frequently long years are necessary to gain from such struggles that unique ability and understanding that enables him to help emotionally the person who is sick. However, we all know that good teachers can help the worker to acquire that ability more speedily. The value of the good nursing or social-work supervisor, and of the effective clinical teacher in the medical school, lies in his being able to teach his students a way of dealing with not only the illness but the patient with the illness as well. It seems to me that this same teaching principle should hold true in the various services given by the health department.

A few health departments are attempting to put such a plan of teaching into practice by having a child psychiatrist take part in the child-health conference. Sometimes a psychiatric social worker goes with the public-health nurse on visits to the homes. The results are heartening. The staff per-

(Continued on page 63)

TRENDS IN DAY CARE

ALICE T. DASHHELL, *Field Secretary Child Welfare League of America*

WE HAVE NOT yet seen the ultimate results of all the wartime work and planning that American communities did to provide day-care services for children of working mothers. But it is certain that gains in the field of day-care have been made and that we have learned certain valuable lessons in the process of organizing the services.

First of all, we have learned much about community planning, with implications for other child-care programs as well as for day time care. There is no doubt that on the child-care committees that labored throughout the war years there was represented a greater variety of interests than was true of other program-planning groups prior to 1941. Think of the average composition of the wartime child-care committees. There we saw the social worker, the educator, the physician, the psychiatrist, the nutritionist, the clergyman, the member of C. I. O. and of A. F. of L., the representatives of local, State, and Federal agencies, the parent, the employer, the businessman, the newspaper reporter, and other citizens sitting down together with a common concern and a common purpose.

Such groups achieved amazingly good and speedy results. It is no wonder, however, that there should be some confusion in their joint thinking as to their basic responsibility. Was it to the individual child, whose mother was a defense worker? Was it to the country at war, needing workers for war industry? Or was it for protection of groups of children from neglect,

introduction of preschool education to large communities, and education of parents? It was the rare child-care committee that saw its first responsibility to the individual child as a member of his family and of the community and as a future citizen. The skills represented on various committees were, as a general rule, no better unified in designing services to meet the needs of children than the skills represented on the staffs of the majority of wartime child-care centers and the presently operating day nurseries. Hence it is quite simple to understand why there

have been and continue to be certain serious lacks in the programs of these facilities.

To many communities, accustomed as they are to the old concepts of need and service—that of the “underprivileged” or “inadequate” individual or group needing the help made possible by the privileged and the adequate—the apparently self-sufficient working parent with a good income and a child requiring care brought a new problem into the picture of community services. The child-care committees accepted the responsibility for local and Federal planning

Time out for milk. And the people who have charge of the day-care center know that milk helps to keep children well nourished.



for children. But some of them thought: "Surely these are adequate parents. Therefore if we care for their children, it must be with few questions asked. The reason that these parents need service is apparent. Our Nation is at war. Mothers, most regrettably, are employed in war industries and other essential occupations. Fathers are in military service."

Some educators were doubtful

Many of the educators, unaware of the difference between the professional social case worker and the depression-recruited "relief investigator," and unfamiliar with the serious problems involved in even partial separation of children from their parents and their homes, were suspicious of the suggestion that "counseling" or case-work services be included in a program of daytime care. "These parents would not use the service if it were related to welfare," they said. And they added, "Parents don't like social workers."

Under public-school administration—the auspices for the majority of these wartime day-care programs—children were admitted for care, as they are to the schools, with few questions asked.

How about fees?

It was hard, too, for the school people to charge a fee for service since this procedure was not compatible with the philosophy of free, public education. There was little more thought about sharing responsibility with parents for the care of their children in these centers than there is, usually, in sharing responsibility with parents for the process of educating their children.

Social workers encountered the same pitfall. "Our services are greatly needed in other areas," they said. "These are adequate parents. Or," they added doubtfully, "most of them are. They don't need us, at least not much. An adequate American parent is independent and can be expected to make suitable arrangements for the child, provided there are good facilities to be used. We don't know much, if anything, about nursery schools. That's the educator's job. Now, as to placement in foster-family homes by the day, we do know something about that. We'll recruit, study, and select day-care homes, even though we can ill afford the

time. And in order to save time we'll put the responsibility for placement and fees right where they belong, on these adequate parents."

The doctors, too, were sore pressed; and because of the number of their colleagues absent in military service they found it difficult to carry the load of civilian patients and also to give service to groups of presumably well children. "These parents are responsible for the health of their children," the doctors said. "Most of them can see their own family physicians. Yes, group care of young children is hazardous to health, but with reasonable precautions, they'll be safe enough. And then there is the public-health nurse. Why not use her?"

The ranks of the public-health nurses were depleted by military service demands, as well. Yet in many day-care programs the only medical service available for the children in care was that of the overburdened district nurse, who came into child-care centers for health inspections and to consult with staff workers. By the time she arrived, probably a child with a sore throat, or other evidence of a communicable disease, had mingled with a number of children in the group. Children with allergies and mild cardiac disorders were often overlooked, and they continued in care undiagnosed. Many parents had no family physicians, and there was little time for clinic attendance.

These parents were for the most part adequate parents, but not adequate educators or case workers or physicians. Their need was—and is now—a service for their children, who for one reason or another required care away from home during the day; a service that reasonably should be expected to protect, preserve, and promote the health, growth, and development of each child, from the standpoint of his physical, intellectual, and emotional needs.

Service to the whole child

Although the majority of day-care programs, both group day care and family day care, fall far short of that objective, the present trend in those fields, if the work of the most progressive agencies can be considered to indicate it, is to plan, to recruit per-

sonnel, and to operate, with service to the whole child as their purpose.

Once an agency, be it a day nursery or a family day-care placement service, grasps this concept, and a few have done so, the problems of accomplishment are relatively simple.

As a day-care consultant, expected to answer at a moment's notice a variety of questions ranging from how to budget to the best way of keeping nursery floors clean, I have found it of never-failing value to respond with a question of my own. That question is simply, "What do you think will produce the best service for this child and for these children?"

It is encouraging to watch boards of directors and staffs reorganizing their services, developing and using new methods, and obtaining the necessary funds from their communities in response to that one simple question.

Plans developing

To illustrate situations where some of these new ideas are being put into effect, here are one day nursery and one family day-care agency. Some of their plans are in a state of flux; but plans there are, and much has already been accomplished.

In a midwestern industrial city there is a large day nursery, which until less than a year ago provided only fair custodial care to upward of 100 children, ranging in age from 2 to 12 years. Three years ago children under 2 years of age were also admitted for group day care, but these babies are now referred to the family day-care agency for individual placement with suitable day-care mothers. Until the early part of this year there were in addition seven child-care centers, subsidized by Lanham funds. The council of social agencies, foreseeing the serious effect upon children in the community of the sudden termination of these latter services, planned with the board and staff of the day nursery to strengthen that agency and to include under its administration the operation of from one to three of the former Lanham centers, with a grant of community-chest funds.

At present the staff of this day nursery includes an able executive director; a social worker; a bookkeeper-secretary; a physician, part time; and

group teachers and assistants, a number of whom are qualified nursery-school teachers. A young and capable ex-sergeant is employed, part time, as recreation leader for the older boys. He will serve full time during the summer months. A girls' group worker will also be employed in the near future.

Other plans are especially noteworthy and are expected to materialize within a year. These are: (1) Arrangement with a nearby university, which has a department of early-child-

rents as part of their pediatric experience under the supervision of the consulting pediatrician. (5) Shortening of the daily schedule for children through explaining to parents the advantages for these youngsters of their coming to the nursery an hour later each morning and returning home an hour earlier each afternoon.

Like many nurseries, this one has continued to operate from 6:30 a. m. until 6 or 6:30 p. m., 6 days a week, with no thought until recently that

able to obtain the necessary funds. And thirdly, it sees (1) the importance of a day-nursery service that combines the skills involved in pediatrics, in nursery education, in group work, and in case work; and (2) the advantage of training programs in which these professional groups cooperate. It sees also the implications for children's institutions of this training and the integration of these skills in group care of children.

The family day-care program that



It's outdoor playtime at this day-care center. While the mothers of the children are at their work they can feel sure that their children are happy and are well taken care of all day long.

hood education, for placement of students for practice training in the nursery, under the supervision of the well-qualified educational director. (2) In-service training, by this educational director, of the present staff, a number of whom are not qualified except by interest in children and by personality. (3) Appointment of a fully qualified case worker, in addition to the present social worker, who has completed only a year's training. (4) Part-time leave of absence for this social worker so that she may complete her training. (5) Arrangement with the nearby school of social work for placement of one or more students for field work, under the supervision of the new case worker. (6) Appointment to the staff of a well-qualified pediatrician to replace the present physician, who is lent by the city health department. (7) Ultimate arrangement with a medical school for service from medical stu-

many parents can shift their work schedules to better advantage if they understand the needs of their children better. An eighth plan may also be made some day, to include student nurses as trainees in this program. Many nurseries have already experienced the advantages of cooperating in such a plan with local hospitals that are seeking opportunities for their student nurses to work with well children as part of their pediatric training.

Before considering the sample family day-care agency let us evaluate the foregoing factors in a good day-nursery service. First of all, the most significant indication of a new trend in the group day-care field is the fact that this community, through its council of social agencies, is recognizing the importance to children of adequate day-care service, adequate both in quality and quantity. Secondly, with this concept of service it has been

I wish to describe has several unique features. In the first place it is set up for the purpose of placing children in foster-family homes for daytime care and is not an appendage or department of a child-placing agency. This is important to note because experience has shown that parents are more inclined to use this type of service if it is offered by an agency organized for the purpose and is not a part of an agency with a different primary function.

The agency under consideration is incorporated, is supported by the community chest, and is recognized as a case-work agency in the community. Its recruiting, home-finding, home-study, selection, and placement procedures are comparable to those of good standard child-placing agencies. It has two pediatricians for examinations of children before placement and for periodic reexaminations.

Recognizing the importance of shar-

CHILDREN OF WORKING MOTHERS STILL NEED DAY CARE

ing responsibility with parents for the care of their children, the agency permits the parents to have their children examined by their family physician if they prefer such an arrangement, and also permits them to pay the fees for the day-care service directly to the day-care mothers. There are regular rates for this service, and payments are adjusted to the parents' incomes on a sliding scale. This means that the agency budget carries an item for subsidy of the service in some cases, in the same manner that is customary in day nurseries.

The agency serves chiefly: (1) Children under 2 years of age, children who for physical or emotional reasons cannot benefit by group care in nurseries, (2) children whose parents' work schedules do not coincide with the day nursery schedules, and (3) children from scattered residential sections where transportation to a nursery is not feasible.

The limitations on the agency's program are: (1) Inadequate payments to day-care mothers for the children's board; (2) the usual difficulty in employing fully qualified case workers during the present-day shortage of trained social-work personnel; (3) failure to expand the service to meet the community need.

Both agencies described have done much thinking about the importance of preparing children and their parents for day-long separation, for the new experience in the group or the family day-care home, and for leaving the experience when service is terminated. Both agencies recognize the essential importance of sharing responsibility with the parent at every possible opportunity and so avoiding the common pitfall of tending to take over responsibility from the parents, which results inevitably in weakening parent-child relationships.

This question is asked repeatedly, "Under what auspices should day-care services be operated and from what sources should funds be obtained?" I offer again the answer, "Under whatever auspices or with whatever resources the child can best be served."

Part of paper given May 23, 1946, at the National Conference of Social Work, Buffalo, N. Y.

Reprints available on request

Even though public day-care programs for children of working mothers no longer receive Federal assistance, many communities are making efforts to continue this service.

An example of these efforts in cities is found in Philadelphia, where continuance of 17 child-care centers was assured on June 17 through action by the city government.

Another is in Washington, D. C., where Congress has authorized the District Government to operate 14 centers until June 30, 1947.

New York City, which did not receive assistance from Lanham Act funds, as it was not a "war impact" area, is continuing to receive aid from State funds, as it did in wartime.

In New York State \$2,175,000 of State money is available to aid day-care centers until April 1, 1947.

In the State of Washington the legislature has voted \$500,000 to provide State assistance for 2 years.

California has enacted legislation to continue child-care centers until March 30, 1947, with a State appropriation of \$3,500,000.

Massachusetts has authorized operation of child-care centers for children 3 to 13 years of age when the local school committee in a city or town decides there is need for such a program. The State may reimburse municipalities for part of the cost of the centers. There is a limitation of \$15,000 annual reimbursement to any one town or city.

At the peak of the wartime child-care program, in July 1944, the program financed with Federal funds under the Lanham Act was serving nearly 130,000 children in more than 3,100 centers.

By July 1945 the enrollment had dropped considerably, but it was still nearly 102,000 and there were nearly 2,800 centers.

On February 28, 1946, the last day on which the centers received Lanham Act assistance, the number of centers, or units, was 1,479. These were located in 386 communities, in all but 2 States.

A month later, answers to questionnaires sent out by the Federal Works

Agency showed that in spite of the withdrawal of Federal assistance more than three-fourths of the centers were continuing to operate. The information collected by the agency from the questionnaires is reported in the July 5 bulletin of Child Welfare Information Service (now called Social Legislation Information Service).

During the war, the bulletin reminds us, Federal funds provided two-thirds of the operating cost of the centers under the Lanham Act program. Fees made up most of the remainder, with some small contributions from States, municipalities, industry, social and civic organizations, and other groups.

After the Federal funds were withdrawn it was necessary, if centers were to be continued, to find sources of considerable funds. And a variety of sources was found.

More than half the day-care centers were in three States where State funds were available for operating them. Funds for the rest were granted by such sources as county and city governments, especially the education authorities; industry; labor unions; colleges and universities; private social agencies; public welfare departments; child-care committees or associations; churches; civic organizations; housing or tenant groups; private donations; and fees.

As for operation of the centers, public-school authorities were operating the greatest number on the date of the report, according to the Federal Works Agency. Next came child-care committees or organizations; then, private social agencies. Others operating centers included industry, private individuals, parents' and other local groups, city governments, local housing authorities, church groups, and colleges.

The report states that a very substantial gain has taken place in programs for care of children of working mothers. Before the war few if any public-school authorities were operating such programs for care of children while the mothers worked, or were providing funds for such programs. But on March 31, 1946, public schools in 176 places were operating these programs.

CHILDREN AND THE 1946 SESSION OF CONGRESS

EDITH ROCKWOOD, Office of the Chief, U. S. Children's Bureau

CHILDREN of the Nation will benefit from many of the measures passed by the Seventy-ninth Congress, which adjourned August 2, 1946. Some of these measures relate to maternal and child-health and crippled children's services, child-welfare services, aid to dependent children, insurance benefits, emergency maternity and infant care, school lunches, vocational education, citizenship of overseas children of servicemen, hospital construction, and mental health. Congress also passed measures benefiting the children of the District of Columbia; one of these provides for day-care centers for children of working mothers; another for better housing.

Expanded maternal and child-health services

Congress increased from \$5,820,000 to \$11,000,000 the amount authorized by the Social Security Act for annual appropriations for grants to the States (Public Law 719 approved August 10, 1946) for maternal and child-health services, administered by the Children's Bureau, and appropriated this amount for the fiscal year ending June 30, 1947 (Public Law 663 approved August 8, 1946). One-half (\$5,500,000) of the amount authorized is to be allotted as follows: \$35,000 for each State, and the remainder allotted to the States in the proportion that the number of live births in the States bore to the total live births in the United States for the latest calendar year for which census figures are available. These grants must be matched by State or local funds for maternal and child-health services. The other half (\$5,500,000) of the amount authorized, for which matching is not required, is to be allotted to the States according to the financial need of each State for assistance in carrying out its State plan. The terms upon which the funds are to be used remain the same as in the Social Security Act of 1935, as amended in 1939.

The additional funds will permit more rapid extension and improvement of maternal and child-health services administered by State and local health

departments, and are an important step toward making these services available everywhere in the country.

Emergency Maternity and Infant Care

The sum of \$16,664,000 for the fiscal year ending June 30, 1947, has been appropriated for the Emergency Maternity and Infant Care program—administered by the Children's Bureau—for the wives and infants of enlisted men in the armed forces (Public Law 549 approved July 26, 1946). The reduced amount reflects the reduction in the size of the Army and Navy. The high point in this program came in the fiscal year ended June 30, 1945, when \$45,000,000 was paid to State health agencies for this purpose. A million babies have been born with Uncle Sam's help since the program started, in March 1943.

Expanded services for crippled children

Congress increased from \$3,870,000 to \$7,500,000 the amount authorized for annual appropriation for grants to the States for services for crippled children, administered by the Children's Bureau (Public Law 719), and appropriated this amount for the fiscal year ending June 30, 1947 (Public Law 663). One-half (\$3,750,000) of the amount authorized is to go to the State crippled children's agencies—\$30,000 for each State and the remainder according to the need of each State after taking into consideration the number of crippled children in the State and the cost of furnishing services to them. These grants must be matched by State funds. The other half (\$3,750,000) of the amount authorized, for which State matching is not required, is to be allotted to the States according to the financial need of the State for assistance in carrying out its State plan. Here also the terms upon which the funds are to be used are the same as in the Social Security Act of 1935, as amended in 1939.

The additional funds will enable the State crippled children's agencies to do a better job of locating crippled children and of providing diagnosis,

treatment, and aftercare for children who are crippled or suffering from conditions that may lead to crippling. It will mean more prompt treatment for many children and expansion of certain programs such as those for children with rheumatic fever and cerebral palsy, two of the groups for whose care funds have been insufficient heretofore.

Expanded child-welfare services

Congress more than doubled the annual amount authorized for grants to State public-welfare agencies for child-welfare services, raising the authorization from \$1,510,000 to \$3,500,000 (Public Law 719), and appropriated this amount (Public Law 663), which is to be allotted to the States, \$20,000 for each State and the remainder in the proportion that the rural population of the State bears to the total rural population of the United States. Matching by State funds is not required, but Federal funds for local child-welfare services may be used for only part of the cost of services in the local areas.

The additional funds will be used for providing for child-welfare workers in a greater number of rural areas and areas of special need, looking forward to the day when social services for children will be available in every county in the United States. Children who are homeless, dependent, neglected, or in danger of becoming delinquent will benefit from this program. The State departments of public welfare will be able to give local communities more consultation and advice in providing care and protection for children in special need and in promoting more adequate resources for their care.

For Federal administration

An appropriation of \$425,000 was added to the previous appropriation for the fiscal year ending June 30, 1946, for administration by the Children's Bureau of grants to the States for maternal and child welfare, bringing this fund to a total of \$902,535.

The three programs combined provide \$22,000,000 for grants to the States under title V of the Social Security Act.

Children of Virgin Islands will benefit

One of the amendments to the Social Security Act provides that the Virgin Islands shall be eligible for Federal grants for maternal and child-health services, services for crippled children, and child-welfare services, beginning January 1, 1947.

Committee action

The action reported in the previous sections—increases in Federal grants to the States for maternal and child health and child-welfare services—had been recommended by the National Commission on Children in Wartime in 1945 and advocated by many national organizations. The House Committee on Labor, on July 25, reported with amendments, and recommended for passage (H. Rept. No. 2662), the bill for a "Maternal and Child-Welfare Act of 1946" (H. R. 3922). No further action was taken on the bill. The House passed another bill (H. R. 7037), which did not provide for expansion of the programs, except to extend them to the Virgin Islands.

The Senate Committee on Education and Labor held hearings in June on the "Pepper Bill" (S. 1318, companion to H. R. 3922), but decided not to attempt to complete consideration of it so late

in the session. This Committee, however, recommended virtually tripling the appropriations authorized in the Social Security Act for grants to States for maternal and child-health services, services for crippled children, and child-welfare services. A joint resolution to this effect (S. J. Res. 177) was introduced by Senators Taft and Pepper on July 15, 1946, but was not acted upon. When the bill to amend the Social Security Act (H. R. 7037) came over from the House, the Senate Committee on Finance proposed, and the Senate adopted amendments in accordance with the recommendation of the Senate Committee on Education and Labor. The final amounts reported in the foregoing sections were agreed to in conference between the two Houses.

Aid to dependent children

The Federal Government can now share in higher State payments for aid to dependent children and is authorized to pay a larger proportion of the individual payments. The maximums in which the Federal Government may share are raised to \$24 a month for the first child and \$15 for each additional child, as compared with the previous amounts, \$18 and \$12. Formerly the Federal Government (within the maxi-

mums allowed) matched State payments on a 50-50 basis. Now the Federal Government may pay two-thirds of the first \$9 and one-half of the balance within the specified maximum. In other words, when the State makes a payment of \$24 for one child and \$15 for the second—a total of \$39 for two children—the Federal Government will pay \$13.50 for the first child and \$9 for the second—or \$22.50—and the State will pay \$16.50. If a State decides to let the recipients receive the greatest possible advantage from the change in the law, it will continue the amount it already is contributing to that payment. The States that are not now paying as much as the State share under the new plan, however, will need to increase their own contributions if they are to gain the full benefits for their children.

This portion of the Social Security Act is administered by the Bureau of Public Assistance, Federal Security Administration.

Insurance changes benefiting children

Child survivors of veterans of World War II who die, within 3 years of discharge, "under conditions other than dishonorable" or because of disability incurred or aggravated while in service, will benefit from the provision giving to ex-servicemen the status of fully-insured workers under the old age and survivors insurance program. Persons discharged or released more than 4 years and a day after the official end of World War II will not be covered. This change was made to benefit men who had no opportunity to build up benefit rights before they entered the service, and who because they were unable to acquire social-security protection while they were in service would have no such protection for their families in case of their death.

Another set of amendments provides coverage in unemployment-insurance systems for more than 200,000 maritime workers. When these men receive payments in case of unemployment the children in their families will benefit.

Vocational education

The Vocational Education Act of 1946 (Public Law 586, approved August 1, 1946) amends the George-Deen Vocational Education Act so as to authorize an annual appropriation of

Mothers and children like these, in the Virgin Islands, will soon benefit through amendments to the Social Security Act.



\$28,500,000 instead of the \$14,200,000 heretofore available for grants to States for vocational education, thereby doubling the amount formerly authorized for this purpose.

This act is administered by the Federal Board for Vocational Education.

School lunches

A permanent program of Federal aid to the States for school lunches was established by the National School Lunch Act, approved June 4, 1946 (Public Law 396). The appropriation for the fiscal year ending June 30, 1947, is \$75,000,000, an increase of \$17,500,000 over the appropriation for the previous fiscal year. The program is administered by the Department of Agriculture. (For additional information see the August *Child*.)

Overseas children of servicemen

To safeguard the citizenship rights of children of young servicemen who married alien wives while overseas Congress passed a law, approved July 31, 1946 (Public Law 571), amending the Nationality Act of 1940. The amended act provides that any citizen who has served honorably in World War II may transmit citizenship to his child born abroad to the citizen and an alien spouse, regardless of the fact that the citizen parent has not had the length of residence in the United States required by the previous law. This was 10 years, with at least 5 of them subsequent to the citizen's sixteenth birthday. The amended law requires, in order that the provisions regarding the child's citizenship shall apply, that the citizen parent shall have had 10 years' residence in the United States before the birth of the child, at least 5 of them later than his *twelfth* birthday.

Hospitals and health centers

More centers for child-health services and more maternity and pediatric beds in hospitals will become available through the passage of the Hospital Survey and Construction Act, approved August 13, 1946 (Public Law 725). This act authorizes a program of grants to States, including (1) \$3,000,000 for State-wide surveys and planning and (2) \$75,000,000 annually for 5 years for the construction of hospitals, health centers, and related facilities. Two-thirds of the cost of building and equip-



While their mothers are at work, Phil, Betty, and Nan are happily occupied at a day-care center. This is one of the centers in Washington, D. C., where the District of Columbia Government is authorized to continue some centers another year.

ping such facilities must be borne by the sponsors of the individual projects—State, county, or city institutions, or private, nonprofit hospitals. The act is to be administered by the United States Public Health Service.

This construction program is basic to the development of any Nation-wide medical-care program.

Mental health

Children and youth will benefit also from the National Mental Health Act, approved July 3, 1946 (Public Law 487). The purpose of the act is to improve the mental health of the people through (1) conducting, assisting and fostering, and promoting the coordination of research relating to the cause, diagnosis, and treatment of psychiatric disorders; (2) training of personnel in matters related to mental health; and (3) developing, and assisting States in the use of, the most effective methods of prevention of psychiatric disorders and for the diagnosis and treatment of persons with such illness. The United States Public Health Service is to administer the act, which includes provisions for grants to the States on the basis of plans submitted by the mental-health authorities of the State. No appropriation has yet been made to carry out the act.

Day-care centers, Washington, D. C.

An act approved July 16 (Public Law 544) authorizes the Board of Pub-

lic Welfare of the District of Columbia to operate from July 1, 1946 to June 30, 1947, not more than 14 nurseries and nursery schools, in public schools and other suitable locations. An appropriation of \$250,000 was made for this purpose. Care is to be provided for the children of parents (1) who are employed and are financially unable otherwise to provide for the day care of their children or (2) who are so handicapped that they cannot otherwise provide such care. (Formerly day-care facilities in the District were operated by the Board of Education.) The Board of Public Welfare is authorized to fix fees to reimburse the District Government for the cost of personal services, labor, food, and supplies used for the centers, but may waive all or part of such fees if parents are unable to pay.

Housing in Washington, D. C.

Although Congress did not pass the "General Housing Act" (S. 1592) it did pass the District of Columbia Redevelopment Act of 1945 (Public Law 592 approved August 2, 1946), which will permit the replanning of blighted areas and their purchase and resale or lease by the District of Columbia for redevelopment.

This should mean eventually better housing and living conditions for many children of the Nation's capital.

Reprints available on request

SWEDEN IMPROVES SCHOOL HEALTH WORK

ANNA KALET SMITH, *Office of the Chief, U. S. Children's Bureau*

AMONG THE RECENT achievements in Sweden's progressive legislation is reorganization of health services for school children. Such services have been operating for about 50 years in the larger cities, but most of the small towns and the vast stretches of Sweden's forest land, with more than half of that country's population, have been overlooked. Government aid, which in Sweden is considered a requisite for the success of school health work, has been available only in some of the schools maintained by the National Government. In the schools supported by the communes—the 2,500 urban or rural districts into which the country is divided—the health work has been left to the local authorities.

Under these conditions a large number of school children were neglected, the direction of the health services lacked unity, and the information about the services was not comparable. Moreover, the school physicians were concerned mainly with treatment, while little or no attention was given to prevention.

Late in 1943 the National Board of Education, which is the official agency administering public education, proposed a plan for reorganizing public school health services. The plan was approved by the Riksdag (parliament) several months later and was put into effect, with the force of law, in the fiscal year 1945.

Under the new law school health work must be done according to uniform regulations, under the supervision of a central agency, the Office of the Chief School Physician of the National Board of Education.

The school health services are related to the health services for the general population through cooperation between the Chief School Physician and the National Medical Board, which supervises health services for the population as a whole.

The National Government contributes at least half the cost of the health

services in all the schools, urban and rural. Payments are made to the district school boards, provided they fulfill certain conditions set by the law. These aim to assure health services for the largest possible number of schools. Thus, aid cannot be given to an elementary school unless all such schools in the district undertake to fulfill the conditions.

Physicians and nurses must be employed in all schools receiving Government aid. Great stress is placed on prevention of disease. To this end regular physical examinations are required, and cases of communicable disease among the pupils and their families must be reported without delay to the principal, who is to take the necessary measures in cooperation with the school physician.

Also new is a concerted effort for the early discovery of tuberculosis in the schools. Tuberculin tests are now prescribed and are given at the beginning of the school year to newly admitted children and young people and to those whose tuberculin reaction is not known. For children and young people with a negative reaction, vaccination against tuberculosis is ordered, to be followed by an annual test. Those with positive reactions are referred to X-ray clinics.

Any teacher or other school employee with a history of tuberculosis is required to report the fact to the school physician without delay. Teachers who suspect that they have tuberculosis are required to submit to an examination by the public-health physician and to report the results as soon as possible in writing to the school physician. Special measures are prescribed for teachers with active tuberculosis. Newly appointed employees of the schools other than teachers must present a physician's certificate as to the condition of their lungs.

Attention is given for the first time to mental disorders and retardation among school children throughout the country; the school physician is re-

quired to advise the principal about such cases.

A medical record of each school child and normal-school student must be kept by the physician. This record, which must be uniform in all the schools of the country, follows the child from grade to grade and from school to school. Copies of all the records are collected at the office of the National Board of Education, where data are compiled for the study of the results of the school health work.

The school physician also (1) assists in vocational guidance when this is necessary for medical reasons; (2) takes action against overwork by school children; (3) instructs the pupils in personal hygiene and at least twice each term inspects school buildings; and (4) directs and supervises the work of the school nurses.

An annual report must be submitted by the school physician to the school authorities.

The new system has brought about an increase in the school physicians' salaries, which along with their duties, are now prescribed by law, and the employment of many more school nurses than formerly; it also calls for close cooperation between the school and the parents.

Certain differences exist in application of the system to the various kinds of schools.

Elementary schools

In the rural elementary schools receiving Government aid the health work is done by the medical officer of the district. About 400 such officials are employed by the Government for the care of the population in the sparsely settled districts. In urban localities one or more special school physicians must be appointed for the elementary schools.

The question of nurses for elementary schools is solved in the following way: When the population of a district is not more than 20,000, the public-health nurse employed by the Government to

care for the general population in the district also serves as part-time school nurse, receiving no additional pay. However, appointment of full-time salaried school nurses in such districts is permitted by law. In localities with more than 20,000 inhabitants appointment of full-time school nurses is required; each such nurse may not have more than 1,500 children in her care.

Physical examinations must be given by the school physician at the beginning of every school year to children in the lowest, middle, and highest grades; also to all newly admitted children in any grade. The school authorities may order a physical examination of any child. Children seeming to be in poor health may be examined as often as the school physician considers it necessary. Parents, teachers, or school nurses may ask at any time for the examination of a child. Conditions needing attention are reported to the parents.

The duties of the school physician are defined by law. He is required to watch the children's mental and physical development and to take the necessary measures for the protection of their health and for their training in health habits. In a large school with a full-time nurse the physician must have regular office hours at the school—at least once a week.

The nurses help the school physician and also visit the children's homes and advise the parents on the care of the children's health.

The teachers in the elementary schools are required to cooperate with school physicians, school nurses, and parents in measures to preserve the children's health.

Intermediate and secondary schools

Health services in the intermediate and secondary schools were briefly mentioned in the laws of 1928 and 1933. Under both laws the schools were authorized to appoint school physicians, whose duties were to be regulated by the individual schools and whose salaries were to be paid by the district school boards. This arrangement, which depended on the will of the local authorities, proved unsatisfactory. Aid from the National Government is



Under a new Swedish law that reorganizes school health services, stress is laid on the prevention of illness in the pupils.

now available to intermediate and secondary schools for the payment of half the salaries of physicians and nurses, and in some secondary schools their whole salaries. The municipalities are required to provide suitable quarters for the health services, with proper lighting, heating, and equipment. Each of the schools must have its own physician, whose duties are similar to those of the physicians in the elementary schools. In many of these schools nurses also must be employed.

A physical examination is required for each child at the time of admission and of graduation, and for all children at least every other year.

Normal schools

The health services in normal schools and in the practice schools connected with them were regulated to a limited extent by the laws of 1937 and 1938. The services were expanded under the new law, and their entire cost is now borne by the National Government. Every normal school must have a physician and a nurse for the care of its stu-

dents and the children in the practice school. A physical examination must be given to all normal-school students at the beginning of the school year, and to children in the practice schools at the time of admission and in the fourth and the last grades. Normal-school students may consult the physician on their own initiative. Health services for children in practice schools are similar to those for elementary-school children.

If a normal-school student or a practice-school child is absent from class for more than 6 days in succession, a report must be made to the school physician without delay.

The new system of health services for school children has been receiving favorable comments from persons interested in social improvement and is said to have brought about a "revolutionary change" in the care of school children's health in Sweden.

Sources: *Tidskrift för Barnavård och Ungdomssködd*, Stockholm, 1935, No. 1; *Svensk Författningssamling*, Stockholm, 1944, Nos. 584-591; 1937, No. 535; 1933, No. 345; and 1928, No. 426.

National conference on the control of juvenile delinquency

A National Conference on the Control of Juvenile Delinquency will be held at Washington October 21 through 23 on the invitation of Attorney General Tom C. Clark.

Federal officials, representatives of State welfare and health departments, State attorneys general, superintendents of correctional institutions, juvenile-court judges, and police and other municipal officials will be among the 800 persons attending the conference, as well as representatives of private health and welfare agencies, religious groups, youth-serving organizations, organized labor, industry, press, radio, and motion pictures. All the 48 States will be represented.

For each of the 3 days of the conference a morning, an afternoon, and an evening session is scheduled. Only the morning session of the first day will be devoted to speeches. After that the participants will be divided into about 25 panels. These panels will confer on various fields of study concerning the problems of juvenile delinquency and will make recommendations for future action for controlling it.

The scope of the panels is planned as follows: Community coordination, Training institutions, Juvenile-court legislation, Administration of juvenile courts, Detention facilities, Role of police in juvenile cases, Public and private housing programs, Child-guidance centers, Case work and group work, Recreational facilities and services, Youth participation in community and youth-service programs, Volunteer participation in community and youth-service programs, Home responsibilities, School responsibilities, Church responsibilities, Motion pictures, Press, Radio, and a special panel on Federal problems.

A preliminary panel on each subject has been formed, the members of which will be the nucleus for the panel that will meet at Washington in October.

Each of these preliminary panels is now working on a draft of a report, which will be submitted to the members of the complete panel for consideration before the conference begins. When the complete panel meets it will discuss and revise the preliminary reports. The final reports will be published.

Chicago mail-order house fined \$25,000 for flagrant child-labor violations

The largest fine ever imposed for violation of the child-labor provisions of the Fair Labor Standards Act of 1938—\$25,000—was assessed recently by Judge John P. Barnes against a mail-order and chain-store firm in Chicago.

This establishment was first inspected by Children's Bureau representatives in 1942, and the child-labor provisions of the act were carefully explained to the persons in charge. After the inspection, at the request of officials of the firm, the Bureau at three different times sent the firm information on the child-labor provisions of the act.

Early in 1945 the Bureau received a complaint that children under 16 were employed in the establishment more than 3 hours a day on school days and after 7 p. m. in the evening, and that one of the girl workers was only 13 years old.

During the inspection made as a result of this complaint, 106 children under 16 years of age were found to have been employed contrary to the child-labor provisions of the act. Twenty-five of these children were under 14 at the time they were first employed; two were only 12. Two 14-year-olds and one 15-year-old had been employed on manufacturing operations. The other 78 children of 14 and 15 had been employed more than the maximum daily hours permitted children of their ages and had worked after 7 p. m.

Through the United States Department of Justice, criminal action was brought against the firm for willful violations of the child-labor provisions of

the act. The company entered a plea of guilty, and Judge Barnes assessed the fine of \$25,000.

The effect of this fine was noticed immediately; many telephone calls were received by the Chicago representative of the Children's Bureau, requesting information regarding the child-labor provisions of the act. The assessment of such a substantial fine will undoubtedly aid in obtaining compliance with these provisions of the act, not only in Chicago but throughout the country as well.

Mississippi has new youth court act

The Mississippi Legislature in 1946 passed a new juvenile-court law, known as the Youth Court Act, which includes some of the provisions sponsored by the Children's Code Commission. This repeals the existing juvenile-court law and most of the provisions of the industrial training-school act, as of October 1, 1946.

It provides for more adequate care and protection of neglected children and for the hearing of cases concerning children with behavior problems, not as criminals, but as maladjusted children in need of understanding, guidance, and rehabilitation. It also makes provisions for furnishing assistance to the court in securing an understanding of the needs of these children and more adequate facilities for meeting such needs.

It authorizes the appointment by the court, under merit-system regulations, of one or more youth counselors in each county or municipality, or jointly, or the use by the court of a youth counselor furnished by the county department of welfare, to perform any services required by the court to carry out the act.

Specific reference is made to the use of such counselors—or of the county department of welfare—for making social investigations during the preliminary inquiry which the court may make to determine whether or not it should take further action. The counselors are authorized to utilize the technical services made available through the State department of public welfare.—FREDA R. LYMAN.

STANDARDS AND RECOMMENDATIONS FOR HOSPITAL CARE OF MATERNITY PATIENTS. Children's Bureau Publication No. 314. 22 pp. Single copies free on request.

Presents hospital standards for maternity care, representing in general the consensus of present obstetric practice, along with certain recommendations that may be helpful in maintaining obstetric standards under difficult conditions.

OPEN DOORS TO CHILDREN: Extended school services. Prepared by Margaret T. Hampel and Hazel F. Gabbard. Federal Security Agency, U. S. Office of Education, Washington. 1946. 28 pp.

This well-illustrated pamphlet on activities in centers for school-age children offers helpful suggestions to teachers, supervisors, and administrators on the improvement of school services to meet the needs of children. It should help colleges and universities preparing teachers to recognize the changes they will need in curricula for future teachers and should point the way for parents and community groups to derive greater understanding of these services for children.

•
"Back to School" for the boys on our September cover means not only hard study, but plenty of fun climbing in the school playground (Library of Congress photograph by Lee). Other credits: P. 51, (a), (c), and (d), Library of Congress photographs by Wootton for FSA; (b) Pennsylvania Department of Health. P. 53 and p. 55, Library of Congress photographs by Lee for FSA. P. 58, Library of Congress photograph by Delano for FSA. P. 59, Washington Post photograph by Burruss. P. 61, Swedish Travel Information Bureau photograph by Karl Sandels.

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Honors to two excellent photographers were unintentionally misplaced in the credit lines given on photographs which appeared in the July issue of *The Child*, particularly in illustration of Miss Marion E. Hutton's article, "UNRRA Shelters—Unattended Children." Herewith our apologies to the artists, and our amends: Credit for the photographs on pages 13, 15 (right), 27 (top, middle), and 28 (bottom) goes to Charles T. Haacher, New York; on pages 24, 25, 26, 27 (bottom), 28 (top, middle) to Douglas Glass, London.

sonnel feel that they benefit in undreamed-of ways. Parents feel that they are getting something they really want.

What can health-department personnel gain from working with a psychiatrist? A few points will illustrate how the pediatrician and nurse and social worker can find ways to improve the effectiveness of the interview with the person who seeks their help. Many professional people are uneasy and impatient when a parent wants to discuss a condition that is not as concrete a topic as Johnny's or Josie's tonsils. So few know how to listen and to realize how great a part of psychotherapy this can be. We should all know more about the interplay in the emotional relationship between the giver of and the seeker for help and advice. With this knowledge we can better estimate the therapeutic importance to the patient of the interview.

More knowledge needed

We need to know more also about the various forms of adjustment that members of a growing family need to make to each other and about the failures in such adjustment that occur from time to time. We need to know a great deal more about adult psychology; more about the normal sexual behavior of adults; more about the aging processes of grandparents, which are often reflected directly upon the child in the home. We need to have more specific concepts of the simpler forms of psychotherapy—such as suggestion, authoritative direction, verbal catharsis—so that we can estimate their limitations and know better which to use.

And then we need to know more about the symptoms of mental illness—the psychoneuroses, the affective disorders such as depression and elation, the thinking disorders such as paranoia and schizophrenia, and the acute anxiety—so that a worker will know when he is in hot water and needs the help of a psychiatrist.

Gaining and using this newer knowledge will take time, for, remember, it will become a part of the physician, nurse, and social worker only as each

makes an effort to learn from the patients and applies what he learns. Each worker is himself a personality, and many of his difficulties and mistakes in dealing with his patients arise from struggles within his own personality. If the worker wishes to get help in his own adjustment from the teaching of the staff psychiatrist he should be able to get it. This process is really a form of emotional growth of the worker—and sound growth is slow.

Help from consultants

One way that might help in attaining this emotional growth is to have the health-service worker spend 3 to 6 months on the staff of a mental-hygiene or child-guidance clinic. However, this is not entirely practical. Only a few workers could be accommodated because there are only a few such clinics. Also, mental-hygiene clinics are so overworked that there is little time for extra supervision and instruction. Probably a more profitable way would be to have a mental-health consultant attached to each health department. The sole duties of this consultant would be staff training and consultation. This plan is now being considered by several States. Provided such a consulting service is on a constant and long-time basis, consultants could also be loaned the health departments from the staffs of mental-hygiene clinics.

More of these ventures have to be undertaken by health and welfare departments. The people of this country want this mental-health aspect of medical practice, which the legitimate professions offering to serve them have in a large part not been able to give them. Because the public has not been able to get this help in clinics and in doctors' offices, many people have sought a poor substitute in the parlors of the fortune-tellers, palm readers, and other cultists.

Public-health departments then should plan for this additional service to their patients. As a result, the public-health worker will gain satisfaction from his patient's sense of being well cared for. He will also get the pleasant self-esteem that comes from knowing that as a professional worker he is growing in his job.

Reprints available on request

ANOTHER STEP FORWARD

Congress has taken another step forward to conserve the Nation's children. It has virtually doubled the Federal funds available to the States for services to children under the maternal and child-welfare provisions of the Social Security Act.

It is now 11 years since the Seventy-fourth Congress passed the Social Security Act. This act authorized appropriation of \$8,150,000 annually to help the States build up their maternal and child-health services, services for crippled children, and child-welfare services. In 1939 Congress increased this authorization to \$11,200,000.

These grants helped greatly. But the funds had to spread so thin that the services have been inadequate. And large numbers of children who need services have had to go without them.

Many counties are still without maternity clinics, well-child centers, school-health services, and the like; some do not even have a public-health nursing service. Last year 20,000 crippled children were on State lists to receive care but could not get it.

Mothers—200,000 of them a year—are having their babies without a doctor in attendance; thousands get no medical attention before the baby's birth. Children are growing up with little or no supervision of their health and virtually no medical care.

The needs of socially handicapped children are as great as those of the physically handicapped. Children in jail, orphans, runaways, children in homes where there is marital discord, children with early behavior problems—these are only a few of the types of children that need child-welfare services. Yet five out of six counties have no full-time child-welfare worker paid from public funds.

Realizing the great needs that still exist, the Seventy-ninth Congress has increased the sum available annually to the States for these needs to \$22,000,000.

With Federal funds virtually doubled, and with each State's own funds also, the States hope to care for additional thousands of mothers and children each year. Also to reach many crippled children who could not be reached before and to help them grow up happy and self-supporting. And to serve a larger proportion of children who are homeless, dependent, or neglected or in danger of becoming delinquent.

New groups of physically handicapped children will be included in many State programs. More children with rheumatic fever and heart disease will be cared for. Programs for children with cerebral palsy will be developed, as States and communities organize the services of doctors, nurses, physical therapists, and others to make up the teams of workers required for a

good program. More children with hearing and vision defects will receive care.

Some States will pay special attention to health services for preschool or school-age children—preventive, diagnostic, and treatment services. Programs to care for prematurely born infants will be high on the priority list.

Child-welfare services will be available to more children as the States can engage more full-time workers. And these workers will give better service as the States can provide graduate training in recognized schools of social work. More counties will get regular help from child-welfare consultants.

All the States are ready to begin expanding their children's services. And they will continue to lay stress on improving these services in rural areas.

The Children's Bureau, as in the past, will approve State plans and will be the Federal agency through which the States receive the grants.

The new funds will not enable the States to do the whole job. Far from it. But all the States now have the chance to build—on the foundation they have laid in the past decade—more of the well-rounded services that some day must be within reach of every child.

Martha M. Eliot

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Associate Chief, Children's Bureau.

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Katharine F. Lenroot, Chief

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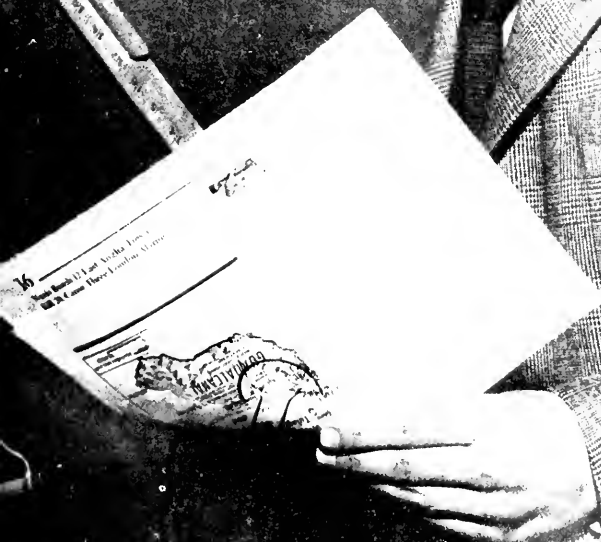
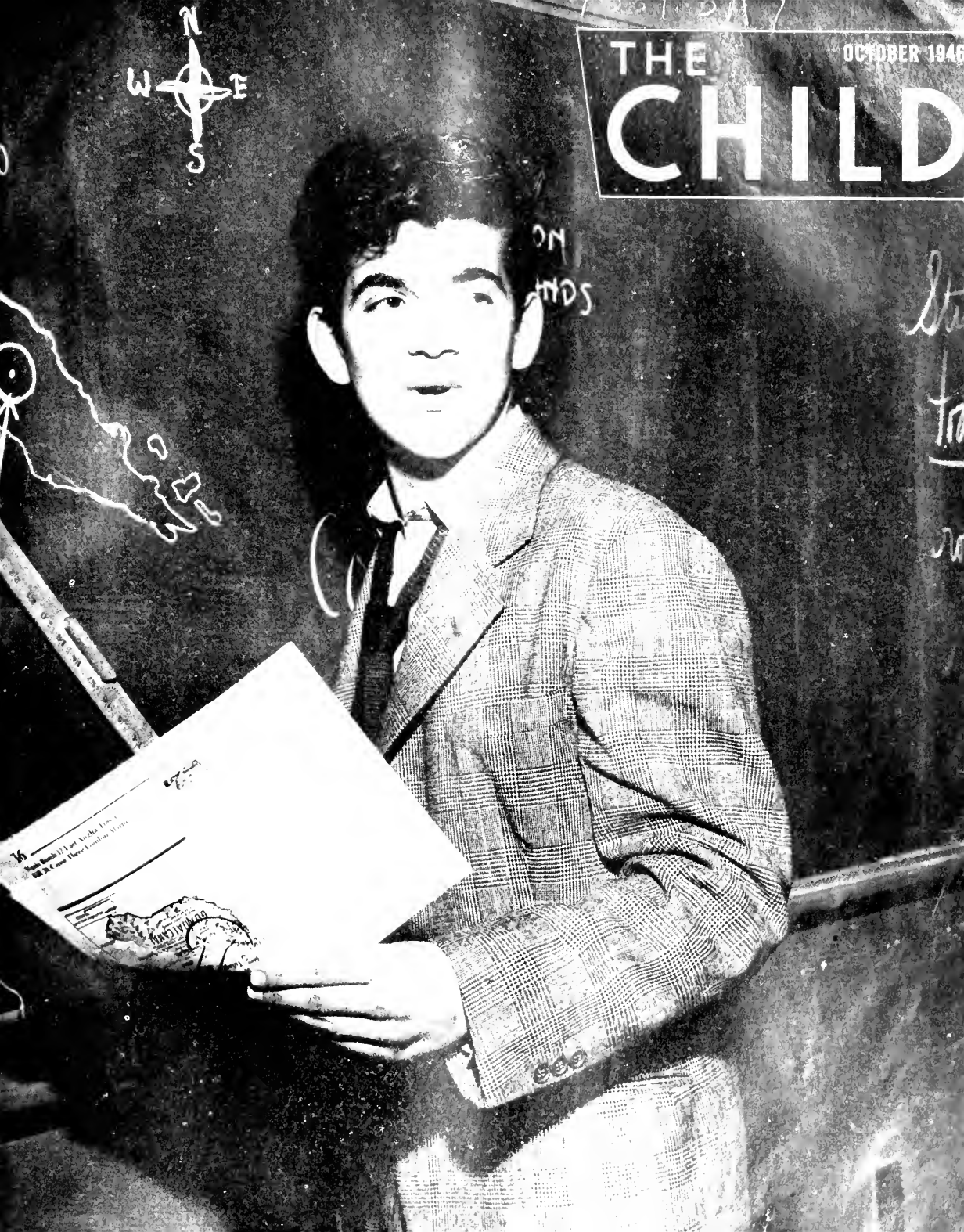
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THE CHILD

OCTOBER 1948





Gathered around the table, the midwives listen to the nurse-midwife, who is telling them how important the birth certificate is.

ARKANSAS TEACHES HER MIDWIVES

MAMIE O. HALE, R. N., *Certified Nurse-Midwife, State Board of Health, Arkansas*

IN THE RURAL sections of Arkansas the "granny midwife" still has her day.

Many people say, "Why don't you get rid of those old midwives?" But those of us who have occasion to work closely with the midwives and the people whom they serve say instead, "Stand by the midwife and help her as much as possible, since she is still a much needed person in her community."

In 1944 nearly 70 percent of all the nonwhite births in Arkansas were attended by midwives. The percentage of deliveries by midwives would be even higher if we were to exclude three counties where there are more Negro doctors than average for the rest of the State and also some hospital facilities for Negro patients.

In 1944 there were nearly 1,500 midwives in Arkansas, and they reported more than 7,000 births. Of these midwives 788 had permits, granted for that year, and 188 of the "permitted" midwives did not report any births. More than 4,000 births were reported by the 600 active "permitted" midwives. The

midwives that had no permits—about 700—reported more than 2,700 births; about 400 of these midwives had formerly held permits.

In order to strengthen the program with the colored midwives, the State board of health recently employed a Negro field nurse-midwife. A nurse-midwife is a graduate nurse who has had a special course in midwifery.

The field nurse-midwife should have, besides her training and experience as a nurse-midwife, training and experience in public-health nursing.

The field nurse-midwife works directly with the midwives in their own communities. She helps the granny midwives by teaching them in classes and by giving demonstrations in the home before delivery, at the time of delivery, and during postpartum care.

About three-fourths of our midwives cannot read or write at all, and only about 5 percent can make out a birth certificate satisfactorily. They are extremely superstitious and bring their superstitions into their midwifery.

In spite of their lack of education

they enjoy in the community a special position of respect comparable to that of a preacher, a teacher, or any other community leader. Most of them are deeply religious and do right as they know it, but even so, their midwife practices are often so far from safe that the State board of health must necessarily take steps to change them even in the face of their fixed notions and deep religious conviction.

At present, the average age of the midwife is from 60 to 80 years. Generally speaking, the older the midwife the more confidence the community has in her. There is some hope that this average age can be lowered, for during the past year, through the work of the field nurse-midwife and the public-health nurses in the counties, a few younger women have become interested.

In one county a school principal's wife who is a retired school teacher and who has a B. A. degree enrolled in the classes and became a midwife. In one county two young married women in their early thirties did the same.

The new midwife, young or old, is much more teachable and accepts instructions far more readily than the midwife who has practiced for years on her own, as that midwife feels that there is nothing that she can be taught.

Midwives are taught the fundamental principles concerning the equipment and care of the midwife bag; the filing of birth certificates; the conditions upon which the midwife accepts a case; prenatal care, including diet; the actual delivery; and postpartum and newborn care.

Besides following the State board's program of instruction, the field nurse-midwife tries to fall in, so far as possible, with the pattern of the midwife's idea of a proper midwife meeting. In some communities the midwives already have organized and have their own officers. These usually take charge of the meeting, turning it over to the nurse-midwife after the business session and the devotional service are completed. These meetings usually open with prayers and hymns. At the beginning the prayers are general, but as the course proceeds, their applications become applicable to the immediate situation. They pray for help in learning what the nurse-midwife is bringing

them on that particular day and even pray for the nurse-midwife and for her approval of their efforts, all in the nurse-midwife's presence.

After the preliminaries the nurse-midwife takes charge of the meeting. The intensive course, which is supplementary to the regular supervision given by the local health department, is planned for seven sessions; the frequency of meeting depends upon the transportation in the community.

In the first session the field nurse-midwife does not have a regularly outlined lesson, but instead just gets acquainted with the midwives. She talks with them about the changing world, of how long she has been a public-health nurse and a nurse-midwife, and of the number of changes that have taken place since she became a nurse. She mentions how our means of transportation used to be by stage coach and horse and buggy; then by train, automobile, and airplane. She mentions how women always used to wear high-topped shoes in wintertime, but now we almost think there is something wrong when we see a woman wearing high-topped shoes. The purpose of citing these different examples is to help the midwife to see that changes in the type of instructions and method of teaching will be necessary if the midwife is to be a modern or airplane midwife. Oftentimes, later in the classes, a midwife will, in reporting another midwife as backward, say, "Nurse, such-and-such a midwife is still 'a-horse-and-buggy-ing,'" meaning she is failing to follow some of the new teaching.

Nurse-midwife studies her pupils

The bag equipped according to standard is shown to each midwife at this session and the list of equipment is gone over with her. At this meeting the nurse-midwife gets an idea who has a bag and who does not. She also gets the granny midwives' interpretation of what goes to make a good midwife, and gives her own interpretation.

At the next session the nurse-midwife shows the class how to fill out a birth certificate. She carries a large-sized replica (44 by 88 inches) of a birth certificate, which has been made out correctly and is used for teaching

purposes. Each midwife is given individual help with her birth certificates. The granny midwife brings to each class meeting a birth certificate that she has made out during the week and the nurse-midwife goes over it with her, showing her any mistakes. Help is also given through visits in the patient's home with the midwife.



At the third session the midwife is taught to consider these questions before she accepts a case for delivery:

1. Has the patient been examined by a doctor? If not, is she willing to go to a doctor?
2. Is the patient a dwarf or a cripple? Or is she having her first child? These types of cases should always be referred to a doctor for delivery.
3. Has the midwife as many as three cases due for delivery in the same week? If so, she should not accept another case due during that period. The midwife is taught that after accepting a case for delivery she should first notify the health department. She should make at least three prenatal visits (more if necessary) to the patient's home. On these visits she should:
 1. Find out whether the patient is under regular medical supervision.
 2. Demonstrate how to assemble the needed supplies and help the patient to do it.
 3. Find out the general arrangement of the house. Help the patient to see the need of using the most convenient room for delivery.
 4. See if the patient is developing any danger signals, such as marked

swelling of hands, ankles, and feet, bleeding, severe morning headaches, severe vomiting, fits or spasms.

5. See whether her diet is right.

Before going on a case for delivery, the midwife should have additional information. If the midwife is given notice ahead of time she will have some of the information already, but sometimes she is called "in a tight" (an emergency, and without previous notice).

1. Is the case "at term"? If not, and if the patient is having a miscarriage, she should be referred to a physician, since a midwife should not undertake a delivery under these circumstances.
2. Has the patient syphilis? If so, has she been under regular medical supervision? If she has not had regular treatment, not only may the case be dangerous for the midwife to handle, but also the child may be born with syphilis.

The fourth and fifth sessions are on prenatal care. At the fourth session the nutrition consultant from the State board of health discusses and demonstrates diet for the expectant mother, during labor and the lying-in period, and for the nursing mother. The midwife is requested to invite her prenatal patients in. At one class on nutrition, 41 people were present, including 25 expectant mothers.

At the fifth session, still on prenatal care, the midwives are taught, first of all, the importance of having a doctor supervise every case.

Medical examination often impossible

Detailed instructions are given concerning what a thorough physical examination by a doctor should include. Here again we run into the problem of the inadequacy of medical facilities, and, even when both the midwife and the patient are convinced of the importance of having the physical examination, it is often not possible to have it. Additional instructions are given on diet, rest, exercise, preparation for delivery, and so forth.

Strange as it may seem, a part of prenatal work is stressing the importance of selecting a name for the baby ahead of time, as great confusion in the filing of the birth certificate can result if the new baby remains unnamed for some time after birth. Midwives are

urged to see that the parents select both a girl's and a boy's name so that the baby can be named at birth whichever the sex.

The sixth session is a 2-hour demonstration showing exactly and in detail just what steps should be taken during a delivery. This includes the set-up for delivery, the actual care that the mother should be given throughout labor, and the proper diet for labor. One of the problems in this connection is the almost universal notion that the delivery should take place on the floor. Here the nurse-midwife points out to the midwives that animals have their young on the floor or the ground and appeals to them with this question: "What are you attending? A dog? A horse? A cow? Or a human being?" This usually appeals to them and most of the time they can be brought to see that a bed delivery is better. Sometimes it is the family that insists on a floor delivery. Here, too, these questions can be used.

At the seventh session after-care of the mother and baby is demonstrated. The midwife is taught how often she should visit her cases and what she should do on these visits and why.

The nurse-midwife arranges to go into the home with the midwife on the first postpartum visit to demonstrate, on this first day, the care in the home, and on the following day to observe and help the midwife to give the care. If the granny midwife has more than one

delivery during the period that the field nurse-midwife is in the area, the nurse-midwife tries to arrange to go with her into the home even on a second case to observe and help her.

Community learns about program

The field work in the county is brought to a close with a 1-day institute to which the public is invited. The purpose is to acquaint the community with what the health department is teaching the midwives; to let the midwives and the people of the community learn of their responsibilities to each other; to give recognition to the midwives who have successfully completed their course of training.

The program for the day includes not only a condensed review of the teachings given during the special class sessions, but, in addition, educational motion pictures and demonstrations, inspirational talks by persons from the State board of health, expressions from the midwives as to what they have learned in the classes, and the awarding of midwife permits and retirement certificates. Usually there is music and sometimes an address of welcome or commendation by local persons.

Both the health department and the midwives have their problems. From the viewpoint of the health department the chief problems are:

Getting the midwife to accept the idea that she should receive and could profit from instructions; finding teach-

ing methods which take into consideration her inability to read and write and her lack of information; coping with her superstitions and being patient in helping her to change from her ideas; educating the whole community, both white and colored, about the work of the health department and the midwives.

A real problem for all concerned, including the patient, is the woeful lack of medical facilities. Even in communities where medical and hospital facilities are available to white persons, at least those who can pay, this is not always true for colored, though in some sections many of these are able and willing to pay.

Another problem is getting the midwife to open her mind to teaching, because so many of them feel that there isn't anything they can be taught. Many say, "I've delivered hundreds of babies. How many have you delivered?" Actually, many such claims are grossly exaggerated. Also, many say that they have received their gift from God. "No man can teach over God," they say. They tell of being called in a vision. A common vision is the appearance of an angel dressed in white, who visits them night after night making cutting motions with the finger—symbolizing the cutting of the cord.

This religious feeling of the midwife and the belief that she has a direct relationship with God in her work must be given consideration at all times. Most of them point to a passage from Exodus as proof of this. "And the King of Egypt spoke to the Hebrew midwives . . . and he said, when ye do the office of a midwife to the Hebrew women . . . if it be a son, then ye shall kill him . . . but the midwives feared God and did not as the King of Egypt commanded them . . . and God dealt well with the midwives."

At first many of the midwives, in the light of this passage, feel justified in resisting the teaching of the health department since "God himself gives us instructions directly." As the instructions proceed, however, most of these come to believe that the new instructions are some extra enlightenment sent by God and that the health department is really an instrument of the Lord, though a few never come to see the need of

At the local office of vital records the midwife is handing in a birth certificate that she has made out for a newborn baby.



being taught. Some, however, take great pride in writing after their signature "A midwife of the State and from God." One midwife who had never heard of the board of health interpreted the opportunity for instruction as a direct and special gift from God to her.



This midwife has been taught to sterilize the removable cotton lining of her bag before packing it to go on a maternity case.

Since most of the midwives cannot read, they have to learn by memory, and often after they have become "letter perfect," there is some question of how much application they make of this knowledge. Their inability to write also makes a headache for the bureau of vital statistics, since the filling-out of the birth certificate is a highly complicated process even for persons of more education.

Some of the superstitions of the midwife are harmless, but many of them risk the life or health of the mother or baby. In coping with these the nurse-midwife tries to meet the midwife on common ground. She may humor the

midwife in such harmless ideas as putting an ax under the bed to cut the labor pains, putting the husband's trousers under the head of the bed so that he can "share them labor pains," biting the fingernails so that the baby "won't be a roguer," or putting salt on the afterbirth as it is being burned so that the mother "won't have no trouble." But she forbids such practices as giving red-pepper tea to make the baby come faster, spitting in the baby's eyes to "keep them from getting sore," putting soot on the cord to make it "heal up well."

The health department needs the cooperation of the whole community, both Negro and white, for a good midwife program. It is sometimes difficult to hold a midwife to the requirements as she often seeks the support of her "white folks" in her resistance to supervision and instructions, and too often they give such support. These white persons are swayed by false sentimentality and often undertake to "protect" the midwife from having to conform to this important health-department program. They do not realize that the program, if carried out, will save mothers' and infants' lives, but that such interference often endangers them.

The midwife has her problems too. Often she doesn't get her pay for the delivery. She has trouble getting the patients to notify her ahead of time of the expected date of delivery. Preferably she should be notified by the fifth month of pregnancy at least. Many patients say that there is no use in letting the midwife know ahead of time, since many of them will not visit the home until the patient is actually in labor. And it is true that many a midwife does actually instruct patients not to call her until they are sure they are actually in labor. When midwives are taught to give a better prenatal service, their patients may be made to see the importance of engaging the midwife ahead of time.

A real problem for the midwife is obtaining transportation, both to the midwife classes and to the homes of her patients. Commonly she walks several miles to the nearest bus station, or thumbs a ride into town. Sometimes she is able to get someone in the neighborhood to bring her into the "meeting

place" for the class, if it is not cotton-picking time. As for transportation to the patient's home, sometimes the midwife must walk; sometimes the family sends transportation.

When will midwives disappear?

The real and final solution to the midwife problem will be her disappearance from the scene when adequate medical and hospital facilities are made available to all at the price that the patients can afford to pay. Until that day the best that the State health department can hope for is to weed out the worst of the midwives and extend an improved supervision over those that are left, gradually replacing even these, if possible, with a sufficient number of nurse-midwives to give maternity care to all who need it.

But qualified Negro nurse-midwives are scarce. It takes a great deal of sacrifice to practice as a Negro nurse-midwife in the rural South. It is hard for her to get her teaching over to the group on account of their age (60-80 years) and their educational level. She cannot enjoy a settled social life, moving about as she does from one community to another. Her teaching hours are irregular, and in addition she has to get up at all hours of the night for delivery calls. She must travel in remote areas at all hours of the day or night. And most important of all, her salary is low for the qualifications necessary. It is low compared to the salary of generalized public-health nurses. And it is very low in view of the great need for nurse-midwives.

Because of the sacrifices required, the Negro nurse-midwife must be absolutely consecrated to her work, just as missionaries, clergymen, and some doctors and teachers are. Although the few women in this work enjoy inner satisfactions that result from having rendered a desperately needed service, the fact remains that there will be no considerable increase in the number of Negro nurse-midwives until salary adjustments are made that will take into consideration the additional experience, qualifications, and sacrifices required of all public-health nurses who are trained in this special field.

Reprints available on request

AN EXPERIMENT IN CHILD WELFARE

EVERY YEAR a quarter of a million children are brought before the juvenile courts of this country as delinquents. At least three times that many get into trouble that brings them to the attention of the police or school authorities but are not referred to the courts for action. A great many others, who are mentally capable of advanced school work and whose parents are able and willing to keep them in school, drop out because they are unhappy and restless. These maladjusted children become maladjusted adults. They represent a tragic loss of human material; and, as criminals or incompetents, cost their communities a great deal in dollars and cents. In most cases something could have been done for them—those who showed actual behavior problems, and those who were merely unhappy—if they had been brought to the attention of the right people at the right time. “The right time” means at the first indications of difficulty or unhappiness, before undesirable attitudes have become habitual. Too often, by the time the child reaches the courts, or even the child-guidance clinic, it is too late to do much for him.

If help is to be given to these children, it will have to be through cooperative community action. No one agency is in a position to discover all the children in the community who need help, or to supply all the types of services that may be needed in treatment. There are obvious difficulties involved in coordinating the work of such diverse organizations as the schools, the police, and the social-service agencies. This is particularly true when they are being asked to cooperate in something as unfamiliar as mental-hygiene work today. But these difficulties are not insurmountable.

Hope to prevent behavior problems

A study of the problems involved in a community approach to the prevention of maladjustment in children was made in St. Paul, Minn., between 1937 and 1943, under the direction of the United States Children's Bureau.

In establishing the project the Chil-

dren's Bureau placed its emphasis on the study of social services to all children with personality and behavior problems, however mild, and of finding ways of preventing development of such problems. The project had three general objectives: (1) to study the problems confronted in the identification and treatment of children presenting personality and behavior problems; (2) to study the problems involved in the development and integration of agencies and organizations concerned with children; and (3) to study ways of interpreting to the community its needs in services to children.

In order to acquire experience that would be applicable on a Nation-wide basis, the Bureau planned the project to be set up in a city of medium size, where the conditions would be typical of the average urban community. St. Paul was selected as such a city. An area was circumscribed for the work, so that the number of children included would not be too large for the purposes of the study. Also in this limited area it was expected that the staff could become personally acquainted with the community and the people serving it. The population of the area was about 20,000 persons. Nearly nine-tenths were native white, about one-tenth foreign-born white, and less than 1 percent Negro and other nonwhite.

The area's record for juvenile offenses was not the worst in the city, but it was somewhat worse than that of the city as a whole. Likewise, figures showing need of the people for financial relief indicated that the area was not the neediest in the city but that its need was significantly higher than that of the city as a whole. Other figures lend support to the impression that the area represented a fair cross section of urban life.

The project staff included a psychiatrist, who was the local director of the project; a psychologist, who was responsible for the psychological service and the program of evaluation; two case workers, one of whom assumed responsibility for contact with the police and courts; a group worker; and a school

social worker assigned by the community to work with the project.

Close relationships were maintained with the city's health agencies.

The project acted on the philosophy that the child should be treated as a whole and his problems considered as a unit. No new techniques of treatment were attempted, but the staff adopted exceedingly flexible procedures in the use of proven techniques and services. Treatment might be intensive, or it might be limited in its scope. The workers adhered to no rigid order in giving services. Group work might be introduced before case work; psychological service might be first or last; all services or only one service might be offered. The total contribution to the



Jack, mischievous and noisy, isn't so likely to need guidance as is his brother, who is quiet and doesn't care to play.

child and the community was considered important, rather than the individual services.

A full report of the work done has been published under the title: *Children in the Community; the St. Paul experiment in child welfare.* (Children's Bureau Pub. 317, Washington, D. C., 1946.) Although the special difficulties encountered, and the solutions arrived at, apply only to the area in which the study was made, certain general princi-

ples emerge which are applicable everywhere.

The first need is to identify the children in need of help. Everybody knows the boy who is clumsy and irresponsible, who trips over anything that is in his way, tears the sturdiest clothes, and forgets to take his school books home. Most people know that these are things he will outgrow, that he is a nuisance rather than a problem, and that all that is needed here is patience. But when asked to list the problem children they know of, this is the type of boy a great many people think of first.

Most people are apt to overlook a quiet, well-mannered boy, who does his work well but refuses to join the others on the playground. Adults probably tell him to run along and play. But as likely as not they do not even hear what he says in protest. The boy who thinks the others do not like him, who believes they all stand together against him, is living in an agony of fear and guilt. He may be an attractive enough child, with no reason an adult can see for feeling inferior or disliked. Frequently the other children do not dislike him; they are merely indifferent because he doesn't seem to want their company. Such a boy may do well in school because he would rather study than be outdoors; all his contacts with adults may be pleasant, since he clings to adults for protection. But he can be a desperately unhappy child and desperately in need of help. This is not something he will outgrow. As he becomes older his feelings become more firmly fixed. The situation perpetuates itself. His attitude, which at first was clearly unjustified, gradually builds up facts which justify it. This is a boy who should be brought to somebody's attention quickly, before serious damage is done.

First aid in mental hygiene

The St. Paul experiment demonstrated conclusively that most people who work with children—parents, teachers, police and probation officers, nurses, social workers, and so on—can learn a sort of first aid in mental hygiene which will enable them to recognize those who are really in need of help. Members of the experimental project staff met with local groups and dis-



Concentrating on their club affairs is keeping this group of youngsters so busy that they have no time to get into trouble.

cussed children's problems, pointing out the kinds of behavior that should be considered questionable at different ages. At first the difficulties brought to their attention were either behavior problems of long standing for which little could be done, or misbehavior that was more annoying than serious. There was a general tendency to report behavior that disturbed others and not to recognize types of behavior injurious to the child himself. All cases were accepted, however, and used as demonstrations of what could and what could not be accomplished. The workers found that the proportion of real problems referred to them increased, and increased in direct proportion to the amount of educational work done with a particular group of adults.

Almost any adult in day-by-day contact with children can learn to identify the children that need attention. To assure proper coverage, responsibility for identification must rest on the largest possible number of workers. But to diagnose the child's trouble is another matter. That requires special facilities and cooperation among numerous agencies.

There is the case of the boy who doesn't get along in school. He pays no attention when he is spoken to and forgets everything he is told. Why? Perhaps he is worried. Perhaps he

cannot keep his mind on arithmetic because he is thinking of what his father said last night when he was drunk, or of how his mother cried this morning. Perhaps he is bored. Perhaps everything the teacher says is so easy and so tiresome, his mind is forced to run ahead inventing more interesting problems for itself. Or perhaps the work is too difficult for him. Too frequently we assume that this is the case and keep him back a year. But unless the child is mentally retarded, and often he is not, this only aggravates his problem.

The difficulties which a child shows in one part of his life—at home, on the playground, in the classroom—never exist in isolation. It is always the whole child that is involved. It is his home life that is affecting his school work; it is unhappiness on the playground that makes him unmanageable at supper. All who deal with children must realize that they are dealing with only one phase of the particular child and that their work and their knowledge must be supplemented from other fields to be really effective. The best diagnosis of a child's situation, the best plan for treatment, can be made only by someone in a position to see the child as a whole, someone who will not give undue weight to the particular problem which has brought the child to

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FEDERAL AGENCIES JOIN IN PLANNING FOR YOUTH

A NATION-WIDE program for youth is needed, says the Inter-agency Committee on Youth Employment and Education. In its report to the Director of War Mobilization and Reconversion after more than a year's work, this committee urges that the Federal Government, as well as State and local governments, participate in such a youth program. Such a program it believes essential in order that each generation of the Nation's boys and girls as they grow up may be equipped to become responsible citizens with a capacity for personal development and social usefulness.

This committee is composed of representatives of agencies of the Federal Government that are particularly concerned with youth. Its chairman is Katharine F. Lenroot, Chief of the Children's Bureau. Its secretary is Elizabeth S. Johnson, Assistant Director of the Child Labor and Youth Employment Branch, the organizational unit that is carrying forward the child-labor program in the Division of Labor Standards of the Department of Labor.

The young people particularly referred to in the report are boys and girls 14 through 20 years of age, at work, in school, or entering the working world. It is concerned chiefly with nonveterans in this age group, as veterans are served, at least partially, by special programs, the report points out.

The committee's report reviews some of the conditions that are bringing about special difficulties that stand between young people today and the opportunities they should have for education and employment. It offers recommendations to the Director of War Mobilization and Reconversion as to what actions it believes the Federal Government should take to advance the opportunities of young people. It suggests some new departures and some new emphases for present programs.

The committee points out that whole regions, many States, and large areas within States are inadequately supplied with elementary- and secondary-school facilities; that the facilities that are available are poor, and that often the schools are too far away from home for

many children. At this time a college education is difficult for nonveterans to get, on account of the large number of veterans enrolled, assisted by GI benefits. And of course, many young people simply cannot afford to get much education even if opportunities are available. The report says that in the upper-income group nearly all the children finish high school, but in the middle group only 60 percent, and of the lower-income group only 30 percent.

Large numbers of young people just out of school are having a hard time getting satisfactory jobs. Employers prefer adults, and expect more in the way of training, education, and personal qualifications than they did during the war. And they are offering less in wages, job security, and promise of advancement. Some boys and girls have to work under substandard conditions and without adequate legal safeguards.

To meet problems of vocational adjustment young people need, more than ever before, the help of counseling and placement services, but these services are available to few.

Not many communities know enough about what is happening to their young people and the job problems they face. And they are not sufficiently aware of what new situations these young people are likely to face. It is in the individual communities throughout the country that services must be developed to meet the basic employment and educational needs of the young people. It cannot be done by governmental action alone.

RECOMMENDATIONS FOR FEDERAL ACTION

The committee sets the following broad objectives for action by the Federal Government to help to solve the problems of young people:

1. School programs that serve the individual needs of all young people at least to 18 years of age or through high school, and higher education for those whose abilities and aptitudes make it desirable.
2. Removal of financial barriers to school attendance due to costs of attending school, including the development of a rounded program for student aid.

3. Suitable job opportunities for young people ready for employment, under varying labor market conditions.
4. Good standards of employment for young people, including safeguards against too early child labor, low wages, and harmful working conditions.
5. Good counseling and placement services for all young people to help them make wise vocational choices and find suitable employment.
6. Community action on behalf of youth that will bring into play all available resources and plan and put into effect programs to serve the individual needs of all its young people for education and employment.

I. School programs

In an effort to provide school programs that serve the individual needs of all our young people the Government should:

- A. Provide Federal financial aid to States in such amounts and so administered as to make possible development in every State of broad and varied school programs adapted to the individual needs of all youth, including guidance services of high quality and a proper balance between general education and specialized vocational programs.
- B. Provide Federal aid to States for construction of educational facilities.
- C. Press forward on action as recommended in the report, "The Veteran and Higher Education," to increase as rapidly as possible the facilities of universities, colleges, and technical institutes.
- D. Provide funds and staff for more extensive consultant service on improved methods of education for both in-school and out-of-school youth and on methods of developing guidance services in the schools.

II. Financial aid

To remove financial barriers to school attendance due to costs of attending school the Government should:

- A. Formulate a Nation-wide program for providing financial aid to stu-

dents in secondary schools and in institutions of higher learning, with sufficient funds provided to conduct research needed for this purpose. (The committee has undertaken preliminary explorations along the line of student aid, and copies of a brief report may be had from the secretary.)

- B. Encourage elimination of expenses to students incidental to school attendance—for example, laboratory and other fees, dues for participation in school events, and charges for text books and supplies—and provision of such supplementary services as transportation and school lunches.

- C. Liberalize public assistance to families in need, with special reference to budget allowances for the school expenses and educational plans of young people. Agencies administering grant-in-aid programs for public assistance should give increased consideration to these needs. Federal legislative action is needed to remove the maxima on the amount of assistance the Federal Government will match, and to provide Federal grants to States on a variable basis that will assure proportionately greater aid to States with least financial ability.

III. Job opportunities

As steps in obtaining suitable job opportunities for young people ready for employment, the Government should:

- A. Provide expanded facilities for research on employment conditions under which children and young people work, and consultant service on methods of improving conditions.
- B. Encourage the extension of the national apprentice-training program to all communities where apprenticeships should be made available, thus providing wider opportunity for young people.
- C. Study desirable means of furnishing work and training opportunities for unemployed youth under public and private auspices in case unemployment should become serious. (This should include consideration of programs under conditions of either moderate or critical unemployment, and should be carried on in relation to the work of the Council



Gil and Frances go to and from high school in the bus, but thousands of boys and girls in this country do not get a high-school education because their homes are far from any high school, and there is no transportation available for them.

of Economic Advisers set up by the Employment Act of 1946.)

IV. Employment standards

In order to set up and adhere to good standards of employment for young people, including safeguards against too early child labor, against low wages, and against harmful working conditions, the Government should:

- A. Support revision of the child-labor provisions of the Fair Labor Standards Act to extend their application to employment by the Federal Government, to all employment in interstate commerce, and to employment in industrialized agriculture at any time.

- B. Promote observance of good child-labor and youth-employment standards in the conduct of programs of all Federal agencies, whether such agency is an employer of young persons or an administrator of programs serving young persons.

V. Good counseling and placement services

To help young people make wise vocational choices and find suitable employment, the Government should:

- A. Expand public employment-service facilities so as to make possible a high quality of employment counseling and placement service to all young people in need of it, including

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Laboratories, modern classrooms, good teaching services, and other requirements for good schools cost money. And the States vary in their ability to pay. Some States can pay an average of \$203 per pupil; others can pay no more than \$42.



MEDICAL CARE FOR EVERY FAMILY

REPRESENTATIVES of the public throughout the country, as never before in our history, are joining hands with health and medical-care administrators and members of all the health professions in a review and analysis of the people's needs for health facilities and services. Symbolic of this social movement in the field of health and medical care is the Commission on Hospital Care. The commission is a public-service committee set up to study hospital services in the United States. It is composed of representatives of the public, industry, labor, agriculture, education, hospitals, and the health professions. This commission is preparing a comprehensive report covering the need for health and medical-care facilities, the function of hospitals as community-health and medical-care agencies, and influences and trends in hospital service.

Fortunately, for those of us who are interested in the work of the commission, a monthly Hospital Survey News Letter has been published under the direction of Dr. A. C. Bachmeyer, who is the director of the studies being made by the commission. Persons everywhere who are concerned with the health and welfare of children are rethinking community and State needs and public responsibility for improvement of the health status of children, the true meaning of the term "group practice," and the role of the hospital as a social agency in the community. The following discussion of these problems, from the May 1946 Hospital Survey News Letter, should be of particular interest to the readers of *The Child*.

Public need

"We are faced with the problem of providing all the people with the most efficient and economical medical care possible. A large portion of the public does not now receive adequate medical care. They will not receive it unless a means is found whereby the number of physicians we now have is more evenly distributed among the population.

There is great disparity between the number of physicians in our large cities and in the less populous areas of the country.

"In order that a larger proportion of the public may afford a proper quality of medical care, the services of physicians must be made available at considerably less than present costs. If more efficient use is made of the physicians' time and effort, it follows that their services could be provided at less expense to the individual patient.

"In many small communities and in sparsely settled areas where there are no adequate hospital or diagnostic facilities, it has been almost impossible to attract members of the medical profession to practice. The graduate of the modern medical college is reluctant to practice in an area which has no hospital or other readily available facilities for diagnostic assistance. His education is obtained in large institutions which are well equipped with modern aids to diagnosis and therapy and staffed by able men particularly skillful in one or another of the special fields of medicine. He is cognizant of the need of these aids and the value of consultation in providing adequate medical care. It is largely for these reasons that the present-day physician is loath to go to a region in which such facilities and assistance are not readily available.

"The large number of people residing in these rural areas must have competent medical care. The situation presents a challenge to the medical profession and the American people. How can the medical profession help solve these problems?

Group practice

"Group medical practice is the application of medical science by a number of physicians working in systematic association and having joint use of equipment and technical personnel, with a centralized administrative and financial organization. The coordinated efforts of a group of physicians can provide the individual patient with

medical care of a higher caliber than is possible by equally skilled physicians working separately.

"Since World War I there has been a growing trend toward group practice in medicine. That war provided a stimulus to the movement in that a great many physicians were exposed to the idea as a result of their military service. There are many indications that the experiences obtained in World War II will give additional impetus to this development. The profession and the public are aware of the many advantages inherent in this type of medical practice. When the system has failed, the fault in most instances has been in the organizational structure, the division of income and expense or in antagonisms on the part of the profession.

"The development of specialization in medicine continues to foster the trend toward group practice. Further impetus was given during the last decade by the development of prepayment plans for medical care and hospital service which are readily adapted to this form of medical practice.

"With proper organization, agreement among the members of the group as to financial matters and control of quality of service and other relationships, group practice should be of far greater value to the public and the profession alike than practice by the physician working alone.

"The following paragraphs are devoted to an analysis of some of the problems faced by the medical profession and hospitals in the reorganization of their services to serve the public need more effectively.

Role of the hospital

"An essential feature in the development of group practice in any community lies in providing adequate quarters to house the offices of physicians, their technical assistants, and the equipment for diagnosis and treatment. General hospitals should be the headquarters for all types of medical practice. By providing the facilities required for complete medical care they can become the center about which professional services can be organized in such a way that the benefits of group action would supplement the efforts of individual practice.

"Close association with other doctors stimulates professional activity and in-

terest through personal contact and exchange of ideas. This in turn would preclude the possibility that the individual physician, suffering from self-complacency, would slip into a rut of mediocrity.

"Opportunities for social and professional contacts with men of similar interests, coupled with a proper income, should prove of considerable significance in influencing the graduates of medical schools to locate in rural areas.

"Regular hours plus periodic vacations and leaves of absence for study are

quate supervisory controls designed to eliminate the possibility of individual members treating cases they are not fully qualified to handle is not easily accomplished. The distribution of income among members of the group must be tactfully handled. But many organized groups of physicians have overcome these difficulties through cooperative effort and are now offering more and better medical care in their communities.

"The methods of group practice have been applied in the provision of medical service to indigent patients in the wards of hospitals. However, this system has not been expanded to include service to regular paying clientele in most instances. When the merits of group practice have been recognized as desirable for one group of patients, it would seem logical to apply the method to all patients. It is believed that the formal organization of group-practice units in general hospitals could be effected easily.

"In some areas, the hospital has become the headquarters for a highly efficient and economical medical service in the community through group-practice arrangements. Facilities are provided for doctors' offices in or directly adjacent to the hospital. Methods have been worked out for the common use by all physicians of personnel and equipment, and thus unnecessary and costly duplication of facilities and effort have been eliminated. Under such arrangements, there is often a sufficient volume of work to justify employment of more highly trained and skilled technicians.

"Doctors, having ready access to complete facilities for diagnosis and therapy, are saved a great deal of time in travel between office and hospital and also have expert professional advice available for consultation in special cases with a minimum expenditure of time and effort, particularly on the part of the patient.

"Although primary interest in this regard centers about the voluntary hospital, it should be pointed out that governmental medical service as provided in institutions operated by the military services, by the Veterans' Administration and in many State, county and municipal hospitals is based upon organized group-practice methods."

FOR YOUR BOOKSHELF

YOUTH REPLIES, I CAN; stories of resistance, edited by May Lamberton Becker. Alfred A. Knopf, New York, 1945. 192 pp. \$2.

That "I am always hungry," the unspoken obligato to these stories of wartime, should go on now—after the fighting has stopped—is a major tragedy of our "peace."

The stories are written for children by a distinguished group of 12 authors, some of them natives of the countries they write about. But these vignettes, giving their sharply outlined instances of courage in the midst of terrorizing brutality are perhaps of more value to adults. If these stories by Jan Masaryk, Sigrid Undset, Robert Goffin, and others help to quicken us to a sense of our obligation, they will have put us a little further along the road to "education" as defined long since by Bertrand Russell. We can never, he said, consider ourselves truly "educated" until we are as deeply aware of and moved to action by the hunger of a child on the other side of the world as we would be by the need of our next-door neighbor.

Marion L. Faegre

FAMILY ALLOWANCES IN CANADA: Facts Versus Fiction, by Margaret Gould. The Ryerson Press, Toronto, 1945. 38 pp. 25 cents.

This pamphlet, published as one of a series, "Canada Must Choose," is directed toward criticisms of the Canadian "Family Allowance Act, 1944," including, among others, those made in two preceding pamphlets in the series: "Baby Bonuses: Dollars or Sense?" by Charlotte Whitton, and "The Revenge of the Cradles," by C. E. Silcox. Taken together, these three papers show the range of issues that arise in considering this important addition to the Canadian social-security system. Miss Gould aims to refute objection to children's allowances with statistical and other factual data, and she does not hesitate to make a spirited defense of the measure in the area of social philosophy and opinion.

Edward E. Schwartz



Bim is lucky, for he lives in a place where the doctor can give him regular check-ups. In some regions doctors are scarce.

as necessary and would prove as invigorating to a physician as to any other member of the public. The establishment of a prepayment plan for medical care would provide reliable source of income and would eliminate the need for devoting professional time to the business phases of medical practice.

"There are problems to be overcome. It is difficult to select competent physicians capable of long-term close association with other members of the professions. The establishment of ade-

Two CB advisory committees meet in joint sessions

How the increased Federal funds for maternal and child health and crippled children's services, recently made available by Congress to the States under the Social Security program, can best be used by the States to reach greater numbers of mothers and children was discussed at a joint meeting of two Children's Bureau advisory committees, the Advisory Committee on Maternal and Child-Health Services and the Advisory Committee on Crippled Children's Services, held at the Bureau, September 16-19. State health administrators and directors of maternal and child-health services in State health departments met during the same week, and two committees of the Association of State and Territorial health officers worked with the Bureau on plans for the new programs.

For communities without services

The committees' work at this meeting was directed toward the twofold objective of how the new Federal funds might best be used (1) to make headway in getting these health services to communities now without them; and (2) to lay the foundation for an expansion of the programs to the end that they will some day be Nation-wide in scope and within reach of all mothers and all children.

Chief among the committees' recommendations was one asking that a considerable portion of the Federal money be used for the training of personnel to meet severe shortages everywhere in the country that are today holding back development of these services. Higher salaries for the personnel involved in these programs were also called for as a means of attracting qualified men and women to the field.

Another major recommendation called for establishment of complete maternity-care demonstration projects, such projects to be set up in rural areas of great need and maintained over a period of years to show by example what might

be done in getting comprehensive maternity care of high quality to a group of women who now often lack even the most elementary care.

Specific recommendations looking toward better maternity care called for use of funds for (1) State assistance to graduate schools to provide education for professional personnel needed in maternity-care programs; (2) establishment of blood banks in strategic centers in order to make early transfusion possible and thus save many mothers' lives; and (3) chest X-ray examinations of all maternity patients to detect tuberculosis and other conditions. The need for additional maternity-hospital facilities was also stressed. It was urged that this need be kept to the fore in the hospital-construction program that is now being undertaken with the use of Federal funds.

Similar demonstration projects were also proposed as a step toward getting comprehensive medical- and dental-care programs established where most needed for pre-school and school-age children.

The committee gave special attention to the need for providing better care of prematurely born infants, among whom there is such a large loss of life. Funds would be used, under the committee's recommendation, to assist hospitals in equipping and maintaining facilities for the care of these babies. Funds would also be used to pay for their care, which is long-continuing and expensive, and for the care of sick newborn infants. Trained personnel is also greatly needed in this field, the committee pointed out.

Needs of crippled children

In considering the needs of the crippled children, the committees called for an expansion of services of the kind now in operation to reach more of the orthopedically handicapped, the largest group being cared for. At the same time, the committees put forward the special needs of children with rheumatic fever, speech and hearing defects, epilepsy, and chronic illnesses.

Special attention was directed toward

children with cerebral palsy. The Bureau was asked to make a Nation-wide survey to determine the number of such children and how they are being treated, and also to look into the situation of crippled children, including those with cerebral palsy, in institutions for the mentally defective. Many such children, whose handicap is wholly physical, it was pointed out, are wrongly considered mentally deficient.

Another highly important recommendation in regard to crippled children called for regional planning under the program so that the best use of fully qualified personnel would be encouraged. Such personnel is not always available within the State. By drawing upon the services of specialists in adjoining States, State crippled children's agencies would, under such circumstances, be able to meet many of their problems in getting care to the children on their own lists, the committees pointed out.

Tackling the problem of the need for mental-health services for children and existing personnel shortages in the field, the committees called for the stepping up of training programs in the schools and colleges. A first need, they concluded, was to train people who in their turn could train others. With that end in view, training fellowships should be given to those who would themselves be capable of teaching and of heading new training clinics.

The Children's Bureau was asked to assist and even to finance projects that would carry out selected experiments in professional education in the field of mental hygiene. It was also recommended that the Bureau expand its own clinical staff. Through such a staff, it was pointed out, the Bureau would be in a position to advise the States in the development of their mental-hygiene programs. Another need stressed by the committees was for development of increased hospital facilities for emotionally disturbed children.

On the question of whether or not a means test should be used in determining the eligibility under these programs, the committees voted unanimously that "those knowledges and services which deal primarily with the prevention of disease, the promotion of health in a

positive sense, and the detection of incipient disease form a part of the basic community health program and should be available for every person at every economic level." Furthermore, the committee recommended that for services of this kind the Children's Bureau should insist that no means test be permitted.

On the question of whether or not medical care should likewise be provided under these State programs without regard to the family's economic status, the committees held that it was a somewhat different problem, although "still a problem much more closely related to public health than to poor relief." However, the committees continued, "where funds for medical care are inadequate for universal coverage, preference should be given to those most in need." The committees urged the Bureau to encourage the study and eventual development of a pattern whereby essential medical services might be made available to all, irrespective of residence, race, or economic status.

Dr. Nicholson J. Eastman, Professor of Obstetrics, the Johns Hopkins University School of Medicine, and Dr. Oscar L. Miller, Consulting Orthopedic Surgeon, North Carolina Orthopedic Hospital, served as cochairmen at the joint meetings. Subcommittees were headed by Dr. Edward S. Rogers, Assistant Commissioner, Office of Medical Administration, New York State Department of Health; Dr. Lawrence J. Linck, Executive Director, the National Society for Crippled Children and Adults, Inc.; Dr. Jessie M. Bierman, Chief, Bureau of Maternal and Child Health, California State Department of Public Health; Dr. Wilburt C. Davison, Dean and Professor of Pediatrics, Duke University School of Medicine; Dr. M. Edward Davis, Professor of Obstetrics and Gynecology, University of Chicago School of Medicine; Dr. Frederick H. Allen, Director, Philadelphia Child Guidance Clinic; and Dr. C.-E. A. Winslow, Professor of Public Health, Yale University School of Medicine.

Watson B. Miller, Administrator of the Federal Security Agency, and Arthur J. Altmeyer, Commissioner for Social Security, addressed the committees.

YWCA adopts national public-affairs program

At its seventeenth national convention—its first since Pearl Harbor—the Young Women's Christian Associations of the United States, at Atlantic City, N. J., March 1946, adopted a new public-affairs program. This program, which represents the latest development in the long-continued interest of the YWCA in public affairs, takes up civil liberties and democratic rights, international relations, social and economic welfare, minority groups, education, public health, and special problems of youth. Part of the program adopted is as follows:

SOCIAL AND ECONOMIC WELFARE

* * *

Child labor

In order to safeguard the welfare of children and prevent the general undermining of labor standards,

We will work for:

Strict enforcement and improvement of existing State child-labor laws;

Enactment of [child-labor] laws in States where there are none [that are adequate];

Ratification of the Child Labor Amendment to the Federal Constitution;

Strict enforcement of the Fair Labor Standards Act.

* * *

Employment, training, and vocational guidance

A strong Nation-wide employment service is essential to make sure that available workers and available jobs are brought together.

We will therefore work for:

A strong national service in which States will maintain certain minimum standards of facilities, personnel, and nondiscriminating policy prescribed by the Federal agency.

Appropriations, Federal and State, necessary to administer its program effectively.

Extension of vocational guidance and counseling.

Equality of training and job opportunity for all people regardless of race, creed, sex, color, or marital status.

EDUCATION

Recognizing that the welfare of our Nation is largely dependent upon the intellectual adequacy of its citizens,

We reaffirm our belief in equal educational opportunity for all people of the United States, and will support legislation to bring this about.

We will work for the improvement of educational standards in relation to teacher training, salaries, and curricula.

We will work for personal and vocational guidance in schools for all youth.

* * *

SPECIAL PROBLEMS OF YOUTH

In considering the above program the special problems of youth should always be remembered. Policies should be established which will provide more adequate and more closely coordinated educational, recreational, and economic opportunities for youth.

We will work for—

More adequate recreational facilities for young persons, including the fuller after-school use of school buildings;

Federal, State, and local planning designed to provide adequate educational and work experiences;

Establishment of a special division for youth in our public employment agencies, and more adequate vocational and educational guidance for all youth, in order that they may develop their skills and abilities and become intelligent and responsible citizens in our democracy.

SOURCE: *National Public Affairs Program; a program of study and action. National Board, Young Women's Christian Associations, 600 Lexington Avenue, New York 22, N. Y.*

Henry W. Thurston 1861–1946

On September 19 came the news that Dr. Henry W. Thurston had died that day at his home in Montclair, N. J., at the age of 85 years. He had been granted the boon of a long life and the ability to pursue quietly and hopefully until the very end the task of interpreting child care and training.

At the time of his death Dr. Thurston was engaged in writing a book on the training of children for civic responsibility, a subject in which he had become

interested during his early teaching career in Illinois.

In 1905 he became Chief Probation Officer of the Chicago Juvenile Court, and soon thereafter Superintendent of the Illinois Children's Home Society. In 1909 he was chosen as the head of the children's department of the New York School of Social Work; he retired in 1931.

During the past 15 years he divided his time between writing, cultivating flowers, and keeping in touch with those of the younger generation whose interests he helped to mould.

His notable book on "The Dependent Child," first printed in 1930, has become a classic. It is a vivid story of changing aims and methods in the care of dependent children. Another of his books, "Concerning Juvenile Delinquency," published in 1942, describes the changing perspectives in treatment.

For many years Dr. Thurston was an active member of local and national committees and an officer of the Child Welfare League of America. His faith in the progressive enrichment of child life never ceased to burn brightly.

Emma O. Lundberg

American Education Week

The twenty-sixth observance of American Education Week, November 10-16, will have for its general theme "Education for the Atomic Age." The sponsoring organization is the National Education Association, 1201 Sixteenth Street NW., Washington 6.

Department of Agriculture's Interbureau Committee makes recommendations on child labor in agriculture

The Department of Agriculture's Interbureau Committee on Postwar Programs at the War's End has included in its recommendations to the Secretary of Agriculture the following:

"In addition to being covered by certain social-security programs, farm laborers should be included in the application of labor standards set by either State or Federal statutes, and the provisions of child-labor laws should be

made applicable to all children working for wages in agriculture."

SOURCE: *Report of the Interbureau Committee on Postwar Programs at the War's End*. U. S. Department of Agriculture, Washington, September 27, 1945. 12 pp. Processed.

Child labor in vegetable-packing sheds

Holding that the courts should not treat lightly their responsibilities under the child-labor provisions of the Fair Labor Standards Act of 1938, the United States Court of Appeals for the Fifth Circuit in Mississippi recently reversed a lower-court decision in child-labor cases brought by the Children's Bureau and ordered injunctions against two employers to restrain them from further violations of the child-labor provisions of the act.

Charges against the two companies, both of whom operate vegetable-packing sheds at Hazlehurst, Miss., grew out of inspections over a 4-year period, which disclosed that despite warnings by the Children's Bureau and promises to the contrary on the part of the management, under-age children were being employed, and other stipulations for the protection of young workers were being ignored. At one time 10- and 12-year-old children were found working.

At issue in the case was the refusal of the trial judge to grant injunctions sought by the Children's Bureau against the companies restraining them from future violation of the child-labor provisions of the act. The district court, while admitting that the violations had occurred, stated that the general standing and reputation of the defendants was such as to assure their future compliance with the law.

The higher court, in reversing that finding, maintained that the trial judge had exceeded his authority. "Repeated, persistent, and deliberate violations by the defendants," the court held, "must be balanced against the reputation of which the trial judge spoke. Confronted with facts showing active violations, belief in a future course of law-observance, based merely upon the defendants' reputation of being law-abiding, is not enough. Lip service to a law, with a background of violations, does not guarantee future compliance."

Enforcement of the child-labor provisions of the Fair Labor Standards Act has been the responsibility of the Industrial Division of the Children's Bureau ever since the act was passed, in 1938. Under the President's recent reorganization plan the Industrial Division has become the Child Labor and Youth Employment Branch of the Division of Labor Standards, Department of Labor, and continues to have the responsibility for enforcement of the child-labor provisions of the act.

Cuban Children's Bureau reports on its work

Set up as a wartime agency in Cuba's Ministry of National Defense, the Children's Bureau (Oficina del Niño), in Habana, has been continuing its activities since the end of the war. The Bureau has five divisions, as follows:

Division of Education.—This Division has established a trade school for boys. It takes measures to check street begging by children; and it helps to observe Children's Week and Mother's Day.

Legal Division.—Extension and improvement of birth registration is the work of this Division. It gives free legal aid in cases involving birth registration, legitimation of children, and marriage.

Medical Division.—With the aid of school physicians, this Division has made a survey of the nutrition of school children in several parts of the country. It is planning to study causes of undernourishment and to advise parents about their children's health. Large numbers of bulletins on balanced meals have been distributed by this Division to schools, trade unions, mutual-aid societies, and other organizations. Six lunchrooms for school children are maintained in as many cities. Posters calling attention to the need of proper food and rest for children and observance of other rules of hygiene have been placed in public buildings throughout the country.

Division of Social Welfare.—This Division gives money and clothing to children in needy families in order to enable them to attend school.

Division of Information.—Radio broadcasts on various subjects relating to child health and welfare have been arranged by the Division. It also distributes material for use by lecturers.

In line with its general purpose, namely, to work for the improvement of the physical and mental condition of Cuban children, the Bureau cooperates with other organizations that have similar purposes.

SOURCE: *Informe de Actividades de la Oficina del Niño, Habana, Cuba* [1946].

State school officers' policy on child labor and school attendance

The National Council of Chief State School Officers, at its 1946 annual meeting held February 1-3 at Buffalo, N. Y., included in its statements of policy the following on child labor and school attendance:

Child-labor regulations

The council endorses child-labor regulations to protect the health, morals, and education of all children and to that end urges that child-labor laws be such as to permit all students who can profit from education to continue in school at least through the twelfth grade.

School attendance

The council commends the Nationwide program of encouraging children to continue their education rather than to drop out of school for purely financial remuneration at this time or for any other excuse not essential to civilian and war needs, and in the case of the latter, where only absolutely necessary.

Our October cover picture, a Library of Congress photograph taken by Esther Bubley or OWI, shows a high-school boy who is earning about distant corners of the earth. Too many boys of his age in the United States do not have the advantage of a high-school education.

Other credits: Pp. 66 and 68, by Melville A. Caff for Louisiana State Health Department; p. 67, Children's Bureau; p. 69, by E. A. Powell for South Carolina State Board of Health; p. 70, Library of Congress, by Arthur Rothstein for OWI; p. 71, Library of Congress, by Russell Lee for Farm Security Administration; p. 73, upper, NYA, lower by Philip Bonn for U. S. Office of Education; p. 75, Library of Congress, by Marion Post Wolcott for Farm Security Administration.

St. Paul Project

(Continued from page 71)

another person's attention. This requires an organization or individual whose function is to assess the total situation, who is in a position to gather information from various sources in the community and to call upon the special services needed in treatment.

In the project area in St. Paul this function was carried out by the project itself. Later, the city had its own Co-ordination Center for Community Services for Children, which was part of a total community program. It was established under the direction of the welfare council to develop closer co-ordination between the schools, the police, and the case-work agencies.

In a community too small to justify an organization of any size, the county child-welfare worker might carry the responsibility. But whether it is carried by an agency or an individual the diagnosis and treatment of children's problems will require cooperative work among many dissimilar professions. The St. Paul staff found that they could accomplish this best by means of liaison workers, men and women familiar with more than one profession and able to interpret one to the other.

The report of the work done in St. Paul will be of interest to everyone working with children who present behavior problems and to men and women everywhere who are interested in community planning for services to children. It analyzes in great detail the types of problems that must be expected and the solutions which proved valuable in one particular instance. But it is not a blueprint that any community can follow. The best solution in any case will depend on factors peculiar to that case.

One community can learn from the experience of another, but it must solve its own problems with the facilities at its command. It is to be hoped that many experiments similar to the one in St. Paul will be undertaken and that the findings will be made available to people everywhere working along similar lines.

Single copies of the full report on the St. Paul experiment in child welfare (Pub. 317) may be had without charge by writing to the Children's Bureau.

Interagency Committee

(Continued from page 73)

close working relations with schools and other community agencies serving young people, and stimulation of suitable job opportunities for young people. (A Statement of Principles of Placement Service for Young People can be obtained from the committee's secretary.)

- B. Encourage expansion under State and local auspices of other facilities for counseling young persons both in and out of school.
- C. Expand research in the field of occupational outlook and promote wider dissemination and interpretation of this knowledge to youth, with emphasis on long-range employment prospects.

VI. Community action on behalf of youth

To contribute to community action that will bring into play all available resources and put into effect programs to serve the individual needs of all its young people for education and employment, the Government should make facilities and funds available to appropriate Federal agencies for the encouragement of community action to meet youth needs.

Research and experimentation are necessary to develop means of obtaining a maximum of community participation and genuine coordination of the many services and programs in the local community, and of assuring that the services reach those most in need of them. This program should include study of methods of stimulating and administering services to youth from the points of view of the Federal Government, of States, and of local communities. (The committee has prepared a report, "Your Community and Its Young People—Their Employment and Educational Opportunities," suggesting to communities ways in which they can plan local activities to meet youth needs, and presenting questions on which information or decision is needed. This project is a beginning on which the participating agencies can capitalize if given the staff and facilities to do so. Copies may be obtained either from the committee's secretary or from the Children's Bureau.)

WE JOIN HANDS

I am extremely glad to have the Children's Bureau as a part of the Federal Security Agency family and to welcome the staff as members of that family. We have long had a community of interests and objectives, and I believe our new relationship will facilitate and mutually strengthen our operations.

All the Federal Security Agency programs have a significant bearing on the work of the Children's Bureau, which is designed to promote the welfare of children and young people.

Health, education, and security are primary and essential factors in building the kind of well-rounded lives we believe all children should have. It will be our aim in the Agency to join more closely the various channels of Government leadership and aid in these fields.

I do not mean that operating units within the Agency are in any way to lose their identity.

For instance, with reference to the status and future of the Children's Bureau as a part of the Federal Security Agency, I want to make my position perfectly clear.

I believe that the Children's Bureau should be kept intact and that it should continue to discharge the same functions that it has discharged so effectively in the past.

I believe that the welfare of our children is of such paramount importance to the welfare of America that there should be and must be a specialized agency charged with the responsibility for promoting the interests of children.

I believe that we can retain all the advantages of the necessary integration of these specialized functions with other functions dealing with human welfare, such as health, education, and social security. It is a problem of developing the necessary interrelationships and procedures. These matters are receiving the immediate and continued attention of officials of the Federal Security Agency and I am confident will be worked out so that the influence of the Children's Bureau is not only maintained but greatly magnified because of its opportunity to influence the policy of other units of the Federal Security Agency whose activities affect the welfare of children.

The Federal Security Agency is organized on the basis of four operating divisions. After much discussion, it seemed best from an organizational and administrative standpoint to place the Children's Bureau within the operating division known as the Social Security Administration. However, it is well recognized that the interests of the Children's Bureau not only transcend divisional lines within the Agency, but also transcend departmental lines within the

Federal Government. Therefore, it is necessary that the Children's Bureau have the requisite freedom in maintaining direct contact with other units of the Federal Security Agency dealing with the interests of children and with other departments of Government dealing with the interests of children.

This can be achieved by developing the necessary direct contacts with officials in other divisions and departments at the same time that the Commissioner for Social Security and I are kept informed of any policy developments that may be contemplated or consummated, so that these may be considered in their relationship to other phases of the Agency's work.

We have a big job and a big opportunity. We approach it in a spirit of joint enterprise and mutual helpfulness. The Children's Bureau will be making a tremendous contribution to many of our other activities.

These activities, in turn, will supplement the work in which the Bureau is principally concerned. Because every measure that benefits the family—that promotes health education and security—means a better chance for children.

Watson B. Miller

WATSON B. MILLER
Administrator
Federal Security Agency

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THE CHILD

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Katharine F. Lenroot, Chief

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THE CHILD



SPECIAL PROGRAM HELPS PREMATURE BABIES TO SURVIVE

JANET B. HARDY, M. D. *Physician-in-Charge of Premature Nurseries,
Harriet Lane Home, The Johns Hopkins Hospital, Baltimore*



PREMATURE BABIES are in general poorly equipped to survive in the new environment into which they are precipitated at birth. During 1945 about 5 percent of all the babies born in the United States were born prematurely; that is, they weighed less than $5\frac{1}{2}$ pounds at birth. Prematurity accounted for half the deaths of babies dying during the first week of life and about one-third of all deaths of babies during their first year. The next big reduction in infant mortality must come through increased emphasis on care of these small babies.

With their special physiological needs in mind, a nursery unit designed exclusively for the care of babies born prematurely has been opened recently as part of the Harriet Lane Home, the children's department of the Johns Hopkins Hospital. This unit is designed primarily to take care of babies born outside the hospital, in Baltimore and the surrounding counties of Maryland. It is part of a new State-wide program of care for premature babies.

The program has been planned by the Maryland State Health Department, the Baltimore City Health Department, and the staff of the Harriet Lane Home. It is designed to care for the premature baby from birth until he is about 3 years old.

The nursery unit

The nursery unit was constructed with funds provided partly by private contributions and partly by the Federal Government under the provisions of the

Lanham Act. The plans were developed in consultation with the Children's Bureau and the United States Public Health Service. It is a part of the Harriet Lane Home, but it is completely separated from the other wards of the hospital. The unit consists of four nurseries, a nurses' station, a demonstration room, and utility rooms. Each nursery is so built that it meets the standards for construction published by the Children's Bureau (Standards and Recommendations for Hospital Care of Newborn Infants, Publication 292. Washington, 1943. 14 pp.)

The unit is entered through an ante-room, where cap, mask, and gown are donned and hands washed. One then passes through the demonstration room used for teaching parents and nurses into the nurses' station and chart room, which is the hub of the unit. This room is strategically situated so as to command all traffic to and from the nurseries. It has a door opening into the main part of the Harriet Lane Home. Through this door babies are admitted and supplies exchanged. The four nurseries and the utility rooms open off a central corridor leading from the nurses' station. Glass panels have been placed in the walls between the ante-room and the demonstration room, between the nurses' station and the demonstration room, and between the central corridor and each nursery.

Each nursery is divided into cubicles by partitions, each extending 6 feet from the floor, and glazed in its upper

half; three nurseries have six cubicles each, and the fourth, used as an incubator room and admission station, has four large cubicles.

Facilities for observation and isolation of any baby who is ill, or suspected of being ill, are located outside the premature unit, but very close to it.

Floors, ceilings, walls, and illumination

The floors of the nurseries and utility rooms are covered with heavy inlaid linoleum; the floors of the rest of the unit are tiled. The ceilings are covered with a material that reduces noise to a minimum. The walls have rounded corners to facilitate cleaning and are covered with a washable paint. Adequate illumination for each nursery is provided by two large outside windows and indirect electric lighting, and standard lamps are available.

Nursery equipment and furnishings

Each nursery has a central lavatory for hand washing. An electric suction apparatus, a linen hamper, and diaper cans with top controlled by foot pedal are provided. Each cubicle contains equipment for one infant. This consists of a bassinet or incubator; a bedside table containing toilet articles, a thermometer, and a 24-hour supply of linen; a chair; and an isolation gown. The bassinets are simple steel-band baskets supported in a pipe-metal stand. There are nine incubators. These are of two types, both of which have temperature and humidity control and apparatus for

giving oxygen. Besides the regular nursery equipment, there is a resuscitator for the admission station.

Utility rooms

The formula and medicine room contains a large electric refrigerator in which a 24-hour supply of milk mixtures and other fluids, such as glucose solution and water in individual feeding bottles, are stored. These are prepared and sterilized in the Harriet Lane milk laboratory and delivered each day. This room also contains a small electric sterilizer and the sterile supplies and fluids for subcutaneous or intravenous use which are obtained as necessary from the central sterile supply unit. Here too are kept the bottle warmers and the drugs required for the babies. A second utility room contains a larger electric sterilizer, a sink for washing used feeding bottles, and cupboards for nonsterile equipment. In the small linen room linen and baby clothes are packaged for steam-pressure sterilizing in the central sterile supply room of the hospital and the sterile bundles stored.

Transportation

As it is of utmost importance to place the prematurely born baby immediately in a warm environment, the program includes facilities for his rapid transportation to the nursery in a heated portable incubator, equipped with oxygen and suction apparatus.

Babies born within the limits of the city of Baltimore are transported by the municipal ambulance service of the fire department, under the supervision of the city bureau of maternal and child hygiene, which provides the incubators and is responsible for the sterilization of the equipment. This part of the program has proved very satisfactory and babies have been admitted to the hospital 15 minutes after birth.

Babies born in the counties of Maryland outside the city are brought in by automobile in similar incubators by a public-health nurse of the State health department.

Admission

On arrival at the hospital, the baby is taken immediately to the premature

nursery unit, where everything has been prepared for his reception. He is placed in the preheated resuscitator in the admission station. This unit not only conserves body heat but allows suction to be applied to remove secretions from the respiratory passages, and oxygen to be administered by face mask either in a constant stream or with intermittent positive pressure to establish satisfactory respiration. Here the baby is examined by a pediatrician, and any necessary emergency treatment is given; the eyes are treated with 1-percent silver-nitrate solution, and the baby given the first of three doses of vitamin K (2.4 mgm. intramuscularly at 12-hour intervals). The baby is then assigned to an incubator or a bassinet, depending on his size and general condition.

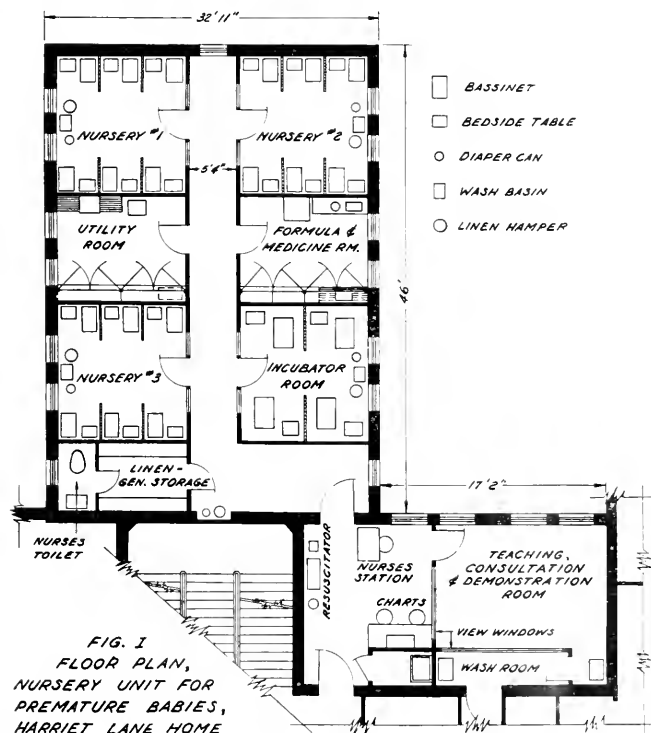
Subsequent hospital care

While the baby is very small and unable to maintain his body temperature at a satisfactory level, he is kept in an incubator at 90° F., with relative humidity of 60 to 70 percent. If his respiration or color is not satisfactory, oxygen is given. Once he is able to maintain his body temperature, he is removed to a bassinet in an air-conditioned room. When he weighs 2,300 to 2,400 grams (about 5 lbs.) he is moved to the discharge nursery, where the atmospheric conditions resemble those he will meet at home. During this period he is taken to the demonstration room, where his parents learn to care for him.

Careful individual isolation technique is observed in order to minimize the opportunity for infection. No one other than the staff responsible for the care of the babies is allowed inside the nursery unit. Until the baby is in the discharge nursery, his parents may see him only through the glass panel.

The first few feedings offered to the baby consist of sterile 5-percent glucose solution in small but gradually increasing amounts, after which he is given cow's-milk feedings planned to meet his nutritional requirements. The feedings are given after the first 12 to 24 hours; at first in small amounts, which are gradually increased until by the time the baby is 8 to 10 days old he receives about 120 calories per kilogram of body weight (60 calories per pound). Subsequent increases are made as necessitated by

This plan does not include facilities for isolation. Babies with infections are isolated in special rooms close at hand.



weight gain in order to keep the caloric intake at approximately the same level. The feedings are given by bottle and nipple to babies who are strong enough to suck and swallow properly. The babies weighing less than 1,200 grams (2½ pounds) are fed first by means of a stomach tube in order not to tire the baby unduly and to prevent aspiration of improperly swallowed milk mixture. Feedings given by medicine dropper are used as an intermediate step between stomach-tube feedings and bottle feedings. The babies less than 1,700 grams in weight are usually fed every 3 hours, day and night; babies weighing between 1,700 and 2,400 grams are fed every 4 hours. When a baby reaches 2,400 grams in weight, the 2 a. m. feeding is omitted, so that by the time he is discharged he is well established on five feedings in 24 hours and need not disturb his family at night. Supplementary vitamins A, B, C, and D are started toward the end of the first week of life. Iron therapy to combat the physiological anemia of the newborn, always more pronounced in the premature infant, is commenced at 6 to 8 weeks of age in small but gradually increasing dosage, so that by the twelfth week full dosage is given.

The baby is not bathed until he weighs 1,800 grams (4 lb.). Before that time he is wiped off where soiled, with a small amount of oil. The eyes, ears, nose, and mouth are inspected each day and gently wiped when necessary with boric-acid solution. In male infants, the foreskin is retracted every day. Circumcision is done only when strongly indicated for medical reasons. This is never done in the first 2 weeks of life.

Fluids such as glucose, saline, potassium, or amino-acid solution are given intravenously or subcutaneously when indicated. Blood transfusion is given toward the end of the first 24 hours to each infant weighing less than 1,300 grams. Blood or plasma transfusions are given to other infants as indicated.

Nursing service and education

To meet the standards for nursing care published by the Children's Bureau (Publication 292), an average of 6 hours of nursing care per day per baby is given, exclusive of the head nurse's time. For the very small babies during the first 24 to 48 hours almost constant special attention is required.

The nursing unit provides a good situation for nursing education. The nursing staff consists of a teaching supervisor, whose duties are primarily teaching and general supervision; a head nurse; an assistant head nurse; and an adequate number of general staff nurses.

Postgraduate students will be admitted for a 3-month course, carrying university credit, in the care of premature infants. During this period they will spend some time in the Growth and Development Clinic in the outpatient department of the Harriet Lane Home, where the babies are followed up after discharge from the hospital; and, in addition, they will be given public-health home-visiting experience in the Eastern Health District of the Baltimore City Health Department. Johns Hopkins undergraduate nursing students will be assigned in groups for 2- to 3-week periods of instruction as part of their general pediatric study. An advanced postgraduate course is being

planned for those students who expect to carry administrative or teaching responsibilities in the organization of new centers for the care of premature infants.

The nursing service is responsible for the parent-teaching program. The teaching is done by the nursing supervisor, the head nurses, and the postgraduate students under supervision. As each baby reaches 2,300 to 2,400 grams (about 5 pounds) in weight and is moved to the discharge nursery his parents are asked to start coming to the nursery at regular intervals. After they are masked, capped, and gowned they are admitted to the demonstration room; the baby is brought out to them, and they are taught how to bathe, clothe, handle, and feed him. Instruction is given in the preparation of milk mixtures and in protecting the baby from infection. The parents are given time and opportunity to handle the baby and play with him. They are taught to regard him as a normal baby, though rather small, and by reassurance an effort is made to overcome their anxiety and emotional difficulties arising from the small size and the immaturity of the child. At the return visits of the child with his mother to the Growth and Development Clinic, the nurses continue this educational program.

Medical service

The medical personnel of the premature unit consists of a member of the Harriet Lane staff, assigned part time to the nursery service, assisted by an assistant resident pediatrician and an interne, assigned on rotation from the Harriet Lane Home staff as part of

In this cubicle an oxygen tank is connected with the incubator, and an electric suction machine for removing secretions from the baby's nose and mouth is near by.

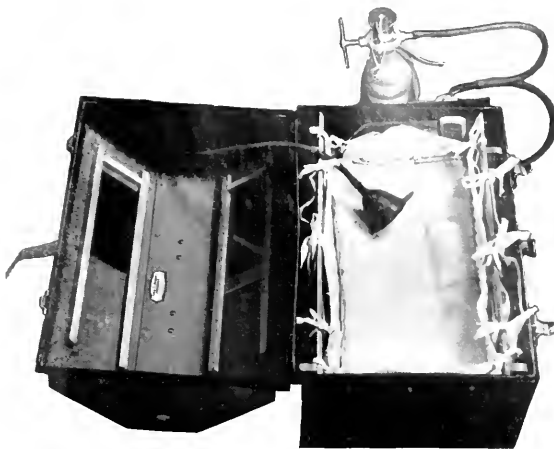


Simple steel-band baskets are used as bassinets for the premature babies who do not need to be given incubator care. The bassinet is supported by a pipe-metal stand.





This portable incubator keeps the premature baby warm while he is being taken from his home to the hospital. Note removable oxygen tank and humidifier.



Inside the portable incubator is a padded cradle for the premature baby and a face mask for giving him oxygen. Warmth is provided by hot-water bottles.

their general pediatric education. These pediatricians have charge of the Growth and Development Clinic and the nurseries of the obstetric department of the Johns Hopkins Hospital in addition to the Harriet Lane premature nursery.

Research

The program has been so designed that additions may be made to our present knowledge of physiological reactions of prematurely born infants. Several studies are under way.

The study that has been going on longest involves a search for retrolental fibroplasia, an eye condition often resulting in blindness. About 120 babies, weighing less than 2,000 grams each, have been studied and followed up.

Another study is in progress to measure the antibody response to pertussis and diphtheria immunizations, and blood samples from mother and child are regularly collected for this purpose.

Studies to learn more about the development of muscular coordination, of sensation, and of the sympathetic nervous system are projected.

In the unit, studies to evaluate the suitability of equipment, such as incubators and other heating devices, are being carried on.

Social service

While the baby is in the hospital, a home visit is paid by the social-service worker attached to the premature nurs-

ery unit—to determine the readiness of the family to receive the baby into the home, to help with any social adjustments necessary for better care of the baby, and to collect information for research purposes.

Public-health nursing service

Two or three days before the discharge of the baby from the hospital, a public-health nurse visits the home, checks to see that the necessary equipment has been obtained for the baby and that no communicable disease or other infections are present in members of the household. She reports back to the nursery unit; whereupon the parents are asked to call for the baby. Upon discharge, a copy of the orders regarding feeding, vitamins, and so forth is sent to the nursing agency. The nurse visits again 24 to 48 hours after the baby has been taken home, and she helps the mother with any problems that have arisen. She sends a written report of this visit to the hospital, and visits thereafter at her discretion. The medical-social worker is ready to help with any social problems.

Medical supervision after discharge

In order to protect the baby from infections, it is planned to have the babies visited at home, during the month after discharge, by a pediatrician on external service from the hospital. After that time the baby will either be under the supervision of the family physician or

will return at regular intervals to the Growth and Development Clinic in the Harriet Lane Home out-patient department. This clinic, from the point of view of the baby's needs, is a well-baby clinic where physical examinations are done, feedings regulated, and immunizations given. From the research point of view, the clinic provides an excellent opportunity for the collection over a long period of time of information relative to the growth and development of premature babies.

The clinic is staffed by the medical personnel responsible for the premature nursery unit, the nursing supervisor, and postgraduate nursing students from the unit. In addition, a dietitian is present to interpret the feeding instructions to the mother. The social-service worker is available and the social-service secretary provides clerical service. The babies are brought back at monthly intervals until the ninth month of life, after which they are brought again at 12, 18, and 24 months unless more frequent visits are indicated.

Provision is made for the immediate care of sick babies through the dispensary of the Harriet Lane Home.

It is hoped that this program will result in a decrease in the infant mortality rate in Maryland and that it will add in some small measure to the knowledge of the physiological reactions of the prematurely born infant.

Reprints available on request

A COMMUNITY EXAMINES ITS DELINQUENCY STATISTICS

ANY COMMUNITY that is trying to prevent delinquency among its children needs to know the dimensions of the problem it is facing.

Some aspects of the problem can be measured by counting the cases that the juvenile court disposes of. But such a count of cases does not tell the community how many children have been referred to the court, for if a child is referred to the court again and again, a case is added to the figures each time, and the totals do not show how many children are represented.

Even when juvenile-court statistics have been revised so that children referred to the court are counted, as well as the cases in which they are concerned, court figures alone cannot give the community the complete picture it needs if its workers are to provide services that are effective in controlling delinquency.

Not every child who breaks windows or steals is brought before the court. Instead, the police alone may deal with the child, or the school authorities. Or several agencies may take part in helping the child to solve his behavior problems without referring him to the court.

Whether a child who gets into trouble is referred to court or not depends on a number of things. It depends, for example, on how well the community has organized its services for children who are in trouble or who are likely to get into trouble. It depends also, to some extent, on the public's attitude toward delinquency at the time the trouble happened. As a result of variable factors like these, the proportion of children referred to the juvenile court varies from community to community and from year to year within the same community.

Some research workers try to get a more complete picture of their community's juvenile delinquency by adding to the court statistics related figures such as number of children arrested, number held in detention homes, and number committed to children's institu-

tions. But the different agencies that report these various figures use different definitions, reporting procedures, and units of count in their summary statistical reports, and as a result it is impossible to get a true picture of the extent of delinquency in this way.

Some years ago an effort to get a quantitative picture of a community's juvenile delinquency during a specific period was made in New York City on an ex post facto basis by Dr. Sophia M. Robison. Dr. Robison studied all the children who had been in serious trouble in the city during 1930. For each child she collated the records of every agency concerned with delinquency that had dealt with him during the year. The results of the study appear in Dr. Robison's book, "Can Delinquency be Measured?" (Columbia University Press, New York, 1936.)

Current, instead of historical, collection of agency data on each child would seem to provide information that could be useful in studying current problems of juvenile delinquency. And so

the District of Columbia's Council of Social Agencies, in cooperation with the Children's Bureau, planned a 1-year experiment in having agencies concerned with delinquency register each case currently with the council. This made it unnecessary to establish a special project for abstracting data from records. The purposes of the experiment were: (1) To obtain a complete statistical picture of the volume of alleged delinquency in the community; (2) to find out what difference there was between the statistics obtained through current registration by all the agencies to which the child was known and the statistics obtained from juvenile court records alone; and (3) to explore the possibility of using registration data in treating and preventing the spread of juvenile delinquency. (A full account of the experiment is given by Edward E. Schwartz in the current Yearbook of the National Probation Association and reprints are available from the association and from the Children's Bureau.)

The six public agencies (exclusive of institutions providing long-time care) that deal with juvenile delinquents in the District of Columbia are: The juvenile court; two service agencies of the police department, one of which deals

Whether this child or that one gets into trouble depends partly on how well the community has planned for them.



with girls and young boys, the other with older boys; two agencies of the board of public welfare, one providing detention care for children waiting for a court hearing, and the other providing services for children in their own homes; and the attendance department of the school system.

These six agencies participated in the registration by sending a report to the council each time a child under 18 was referred to the agency for alleged delinquency; that is, misconduct that might be dealt with under the law. Private agencies were not included, as technical and administrative difficulties were involved; also, preliminary investigation indicated that the private agencies would add only a few cases to the registration.

A uniform concept of delinquency was not imposed upon the agencies, and they made no change in their intake and referral policies and practices. The registration, therefore, is believed to reflect the established relationships of the agencies to the community and to one another. No attempt was made to assess responsibility for the alleged delinquent behavior of the children registered; for example, the children registered by the school authorities for truancy were included whether they were unlawfully absent because of the child's willfulness or the parent's neglect.

The report to the central register usually was a copy of the established intake form or a similar record of initial contact. The information reported included data identifying the child, and administrative data such as date and source of referral to the agency, reason for referral, and date and method of disposition of the case.

Community-wide statistics and basic information for program planning

The total number of cases registered by the six agencies during the year was almost twice as large as the number of children concerned. Obviously this was the result of recurrent registration of a child by one agency and by registration of the same child by more than one agency. There is little question that if the registration had been carried on for a longer period of time the ratio of the number of cases registered to the number of children represented in these cases would have been even greater.



Community services for children need intelligent planning if they are to help the youngsters become responsible adult citizens.

Of the children registered, more than half had not been referred to the juvenile court. This large proportion was due in part to the large number of children registered by the school system for truancy.

The number of cases registered by the juvenile court was almost 25 percent greater than the number of children referred to the court.

On the basis of this portion of the findings, it has been estimated that the reports to the Children's Bureau of delinquency cases disposed of by juvenile courts in various parts of the United States exceed by 10 percent or more the number of children represented by these cases; the difference in some courts is greater than in others, depending upon administrative and reporting procedures.

Beginning with the data for the calendar year 1946, the Children's Bureau has revised its reports from State agencies on the volume of juvenile-court work so as to show the number of the children involved in the cases disposed of during the year. The purpose of this change is to provide local communities and State agencies with more adequate data for planning services to children.

Comparing juvenile-court statistics with community-wide data on delinquency

For each of the 12 months of the study the number of children registered

by the juvenile court was compared with the total number registered by the participating agencies, exclusive of the school system. (The school system was excluded from this comparison because its registrations were reduced sharply at times of the year when school vacations occurred.)

The direction of the changes proved to be similar for the two groups, but the degree of change was considerably different. The court figures alone did not indicate adequately the extent of monthly change in the total number of children who were alleged to be delinquent. Similarly, the court figures showed which areas of the city had the greatest concentration of children alleged to be delinquent, but did not indicate the full extent of the concentration.

As a result of the organization and practice of the public agencies dealing with delinquency in the District of Columbia a larger proportion of the boys registered for delinquency than of girls were referred to the juvenile court. As the children referred to the court represented less than half of all the children registered during the study period, they cannot be considered representative of all the children registered, with respect to sex distribution or to related factors such as age or reason for reference.

A statement frequently made concerning the validity of juvenile-court statis-

tics as an index of juvenile delinquency is that although some delinquent children are not included, generally those children alleged to be involved in serious delinquencies are referred to the court and therefore are included in the court statistics.

During the registration period the reason for referral was an important factor in determining whether or not children alleged to be delinquent in the District of Columbia were brought to the court.

However, a large proportion of children who were reported for offenses that may be considered serious were not brought to the court, and many children alleged to be involved in less serious delinquencies were referred to the court.

The characteristics of the child and the legal-administrative classification of the alleged delinquency in relation to existing community services seemed to be more important in determining whether the child was brought to the court than the "seriousness" of the alleged misconduct.

Using the register in community research and planning

To obtain a community-wide picture of alleged delinquency, important as it may be, is not the sole purpose of a central register. The register makes available data that are potentially of great usefulness for intensive research in juvenile delinquency and in the organization of community programs for its treatment and prevention.

Almost a fourth of the children represented in the register were reported by two or more agencies during the year, and 5 percent were reported by three or more. These children's histories can be assembled from the agencies concerned in order to determine whether they were known to different agencies at different times or whether they had been referred from one agency to another for the same alleged misbehavior. The fact that a child is known to several different agencies may reflect expected referral practices (for example, referral of a child by the police to the receiving home and to the court). Analysis of the experience of children involved in a series of referrals may help to clarify inter-agency relationships, especially as they relate to intake and referral policies. Similarly, the experience of children

who appeared without referral in a number of different agencies during the study period offers opportunities for examining agency policies and practices in relation to follow-up and continued contacts with children known to be in difficulty. Such an examination, for example, may indicate clearly the need for expanding a community's preventive and protective services.

The register also can be used to focus attention on children who are repeatedly referred for alleged misbehavior and who seem to be particularly vulnerable to the pressures exerted by their home life and their surroundings. For example, it is possible to locate one-eighth of all the children represented in the register who were reported four or more times during the year, and more than one-fifth who were in families in which one or more of their brothers or sisters also were reported for alleged misbehavior. Although some of the alleged delinquency may have been trivial in itself, the registration permits selection of families in which misbehavior by one or more children is becoming an established pattern and to direct special services to these families.

A related analysis throws some light on the relationship of truancy to other delinquencies. Almost 3,500 of the children reported to the register were truants. This number includes the "casual truants," who ordinarily would not be treated as delinquents; and only 5 percent of the 3,500 children were referred to the court for truancy. It cannot be concluded, however, that truancy, as a relatively minor form of misbehavior, is unimportant in the delinquency picture. An examination of the registrations for the 3,500 truant children indicates that 17 percent of them were brought to the juvenile court for truancy or for some other form of delinquency during the study period. Thus, inclusion of truant children in the register not only provides useful information on the general relationship between truancy and other delinquency but also assists in the identification of children who need special services.

What other communities can do

The findings of this experimental registration apply only to the District of Columbia for the period studied, and similar registrations in other commu-

nities may yield results that are totally different. Communities may find that the more complex or highly developed their services for children are, the greater will be the variation between juvenile-court statistics and community-wide statistics on alleged delinquency. In large sections of the country, particularly in rural areas, it may be found that court activity represents all, or substantially all, the work with allegedly delinquent children in the community.

The experimental registration of juvenile delinquency in the District of Columbia serves to emphasize the importance to the community of finding out how satisfactorily its juvenile-court statistics represent its total delinquency situation. The method employed is suggestive of what might be undertaken in individual communities, with suitable variations that would take into account differences in the organization of community services for children.

In communities where it is found that the use of juvenile-court statistics alone does not adequately measure delinquency, consideration should be given to the integration of these statistics with those of other agencies into some system for the current reporting of community-wide data on delinquency. This would recognize the important position of the court in the community's program for serving children as well as the important interrelationship between the court and the schools, the police and other agencies.

Community-wide statistics on delinquency, therefore, would enhance the usefulness of the court statistics, as well as the statistics of the other agencies, for administrative, planning, and interpretive purposes. A community's registration of delinquency is only a partial approach to the study of the problems and needs of all its children and provision of services to meet these problems and needs. It is not an end, but only one of the means of indicating the strengths and weaknesses in the community's services for all its children. Statistics of this nature are of value only as they are used in intelligent planning and administration of community programs, designed to give each child the assistance he needs to develop into a responsible adult member of our society.

BETTER TEETH AND HEALTHIER CHILDREN

JOHN T. FULTON, D. D. S. *Dental Services Adviser, U. S. Children's Bureau*

WHAT is a good public dental program for children? Is it using movies, slides, and charts to teach the children about their teeth and how they should take care of them? Is it examining teeth at certain intervals and then telling the children what they can or should do? Is it setting up dental clinics in schools and health centers where children can get actual service on their bad teeth? Or does a good dental program for children include all of these?

Certainly we all agree that good dental health is a vital part of the proper growth and development of children; and that good dental programs are necessary if the children are really to be healthy.

If we examine the patterns in which the States develop their dental programs, however, we find wide variation. The only common denominator is the thing called dental-health education. Even here the emphasis is placed on different methods. Some States put forth their main efforts to acquaint their health staff with facts concerning the teeth. These States stress instruction of public-health nurses and others who work directly with mothers and children. Other States develop programs of education for school teachers, with the idea that the information on teeth will be passed along to the pupils. Still others try to teach mothers and children directly through movies, slides, charts, posters, lectures, and conferences.

In some States a large part of the program consists in inspection of children's teeth, either by dentists or dental hygienists. This is followed up by notifying the parents of the conditions discovered and referring the children to dentists for repair work.

Programs in some States attempt to provide the means for actual correctional service for children with bad teeth. These latter types of programs are generally limited to a few services and are spread thinly to as many children as possible.

The Children's Bureau has been concerned for some time with the effective-

ness of the various types of State dental programs. Forty-seven State health agencies now have dental programs for children or are in the process of developing them. This fact, and the existing variation in programs, points up the need for sound guiding principles to help in building effective public dental programs.

It must be remembered that diseases which attack the teeth are among the most prevalent in the population and that they are particularly active among children, even very young ones. There can be no doubt that effective control of the ravages of tooth disease will require dental services that are very time-consuming and expensive, regardless of the type of program under which the services are carried out.

This being so, there certainly is no room for frills and fads in a public dental program. On the other hand, if good dental health is an important element in the total health of the child, there must not be a low standard of dental care. Children need and should have all the essential dental health services.

Recognizing these facts, the Children's Bureau last fall invited a group of special consultants on dental health to discuss standards and quality of dental care for children and to make recommendations with regard to such care in public programs. This group included authorities in the fields of dentistry for children, public health, research, and general practice.

In considering the program this group made several recommendations concerning principles for dental programs for children, which they believed made a positive, sensible approach to the problem. These principles were approved by the Association of State and Territorial Health Officers in April 1946 and are now being used as the basis of the Bureau's dental consultations with the various States.

The first principle, the group said, was that all programs for children should provide facilities for dental treatment, as well as dental-health education. Education is of questionable value unless some means can be found to help translate ideas into action.

Nettie's dentist is treating her teeth. Good health service requires that this be done at regular and frequent intervals.



As a second principle: If services must be limited on account of lack of funds or personnel, the limitation should be placed on numbers, or on the age groups, of the children to be given care. It is better, the consultants agreed, to provide adequate care to small groups of children rather than to provide limited services to large numbers. Otherwise, in a dental program there is always the danger—because of the great accumulation of needs—of reducing dental treatment to emergency services only. Such services hold no hope of bringing the problem under control.

With regard to the age of children to be given services, a third principle was recommended. This is that the program should begin with the youngest age groups possible and once begun should provide care for these same children every year. As very young children are susceptible to dental diseases, the idea of starting the program with them is sound. Furthermore, the evidence is clear that once the accumulation of dental needs has been taken care of, the problem of keeping these children's mouths healthy becomes much easier, provided that the mouths are examined, and corrections made, at frequent intervals.

One of the hopeful factors about dental disease is that it is a relatively long process, that it develops slowly, from

year to year. Once children have entered a dental-treatment program, the problem of keeping their teeth in good condition is lessened by the simple process of regular examination and treatment.

It is stated as a principle that good dental-health services must include all the essential elements. The question then arises: What are the minimum requirements that a program of dental care for children should provide? The consultants answered this question with the following list:

- A. Examination and diagnosis.
- B. Cleaning.
- C. Repair of decayed or injured teeth.
- D. Treatment of exposed nerves.
- E. Treatment of gums and mouth infections.
- F. Extractions.

A dental program cannot provide less than these services, said the consultants, and still be effective.

Because children of various ages present different dental problems, it seemed necessary to the consultants to set up standards for services for children in several different age groups. Some recommendations were made that would apply to children of all ages, others that would apply to children 3 to 5 years old; still other recommendations for children 6 to 12; and some special rec-

ommendations that apply to the 13-17 year group. By this grouping the consultants were able to set specific standards for the various classes of treatment services that are suited to all children that are served by the public dental program.

These principles for public dental programs for children seem to be a move in the right direction because (1) they set forth a definition of the essential elements in the dental care of children, (2) they provide a sensible approach to the control of the problem, and (3) they offer a program which can be started on a sound basis with almost any limitation of funds and personnel and which can be added to, step by step, as these limitations are removed. As long as the ultimate objective is kept in mind, expansion can take place from time to time as resources become available, and eventually result in the program that produces good dental health for all the children in the most economical way.

Copies of consultant's recommendations are available.

A statement of the recommendations made by the group of special consultants on dental care and approved by the Association of State and Territorial Health Officers has been prepared by the Children's Bureau in mimeographed form, under the title, "Principles for Public Dental Programs for Children." Copies of this statement may be had from the Children's Bureau upon request.

The consultants included: Kenneth A. Easlick, Professor of Dentistry, University of Michigan; Ralph L. Ireland, Professor of Dentistry, University of Nebraska; John C. Brauer, Los Angeles, Calif.; Isaac Shour, Department of Histology, University of Illinois; O. W. Brandhorst, Secretary of the American College of Dentists; Harry Strusser, Chief, Dental Division, Bureau of Child Hygiene, New York City Department of Health; J. M. Wisam, Chief, Division of Dental Health, New Jersey State Department of Health; Leon R. Kramer, Director of Division of Dental Hygiene, Kansas State Board of Health; Ray M. Walls, Bethlehem, Pa.; and Melvin Dollar, School of Public Health, University of Michigan.

Reprints available on request

In this well-equipped trailer, a dentist from the State board of health treats Johnny's teeth while his schoolmates watch.



JOB-PLACEMENT SERVICE FOR YOUNG PEOPLE

U. S. Employment Service Sets Its Policies

On November 15, 1946, the public employment service, which had been operating on a Federal basis, returned to the Federal-State system of operation, under which it had operated prior to the war. Under the Wagner-Peyser Act, which created the Federal Employment Service, the State must submit a plan of operation for approval by the Secretary of Labor before obtaining Federal funds. As part of this plan, each State is being required to submit a statement that it will adhere to the basic standards set forth as United States Employment Service policies and will maintain procedures necessary to carry out such policies effectively. The purpose of requiring such a statement in a State plan is to insure uniform acceptance of United States Employment Service policies.

The importance which that agency places on employment safeguards, on counseling, on services to youth, and on the development of cooperative relationships with schools and other community agencies is indicated by the following excerpts from a regulation recently issued by the United States Employment Service.

The placement process. It is the policy of the United States Employment Service:

(j) To make no referral to a position where the services to be performed or the terms or conditions of employment

are contrary to Federal, State, or local law.

(k) To recruit no workers for employment if the wages, hours, or other conditions of work offered are substantially less favorable to the individual than those prevailing for similar work in the locality.

Employment counseling. It is the policy of the United States Employment Service:

(a) To provide employment counseling service to any applicant of employable age who requires and wishes such assistance in becoming vocationally adjusted.

(f) To cooperate with schools, organizations, and other agencies to:

(1) Plan the most effective use of services and to avoid duplication.

(2) Undertake cooperative projects of mutual use.

(3) Obtain and provide information needed in the counseling process.

(4) Establish and maintain procedures for referring individuals between agencies.

(5) Provide for mutual assistance in strengthening counseling services by interchanging special methods which have proved successful in counseling.

Service to youth. It is the policy of the United States Employment Service:

(a) To facilitate employment of youth entering the labor market by pro-

moting employer acceptance on the basis of qualifications.

(b) To refer young workers to jobs which are not injurious to their health and welfare, and which insofar as practicable offer opportunity for advancement.

(c) To maintain cooperative relations with the schools, training agencies, and other community groups to facilitate the entry of young workers into employment.

Community participation. It is the policy of the United States Employment Service:

(a) To cooperate with other agencies of government, and private and community organizations, to improve the employment process in the community and to participate in community programs for the same purposes.

(b) To make the facilities and technical resources of the employment service available to other Government agencies and public or private non-fee-charging agencies in accomplishing objectives which relate to the placement or vocational adjustment of workers or potential workers.

Source: Federal Register, October 3, 1946, pages 11278-11279. Title 29—Labor, Chapter 1, United States Employment Service, Department of Labor, Part 23, Policies of the United States Employment Service, sections 23.1, 23.3, 23.5, 23.11.

Federal Agency Group Outlines Principles

In its report on "Educational and Employment Opportunities for Youth" (discussed in the October issue of *The Child*) the Interagency Committee on Youth Employment and Education, composed of representatives of the Department of Labor, the Department of Agriculture, and the Federal Security Agency, gave special consideration to counseling and placement services for all young people as part of a Nation-wide program for youth. Its recommendations on this subject

were based on a more detailed statement prepared by a subcommittee on placement services which included representation of the United States Employment Service. This report should aid groups and individuals that are planning and working for extended and improved placement. It sets forth the reasons for giving attention to placement services for young people, outlines the principles that should underlie the service, points out the means for achieving a high quality of service, and

enumerates ways in which these principles may best be applied.

The basic principles that should be applied in developing placement services for inexperienced young people, as approved by the committee, are summarized as follows:

1. It is a public responsibility to make adequate placement services available to all young people.

2. Placement services for inexperienced young people should include,

(Continued on page 95)

Child Labor at Recent I.L.O. Conference

The twenty-ninth session of the International Labour Conference, held September 19 to October 9, dealt with two important aspects of child labor and youth employment—medical examination of young workers for fitness for employment and restriction of night work. The conference adopted three draft conventions and two recommendations, to be submitted to member nations for action. The conventions deal with (1) medical examinations for young workers in industrial undertakings, (2) medical examinations for young workers in nonindustrial occupations, and (3) restriction of night work of children and young persons in nonindustrial occupations. These conventions embodied basic principles, and the recommendations adopted dealt with more detailed matters of administration, so as to allow for adaptation to varying systems of child-labor law administration in different countries.

A more detailed account of these proposals will appear in a later number of *The Child*.

Juvenile-delinquency conference postponed

Postponement of the National Conference on the Control of Juvenile Delinquency to November 20-22 has been announced by the office of Attorney General Tom C. Clark. The conference had been scheduled to meet at Washington October 21-23, but on account of a labor-management dispute affecting hotels in Washington the later date has been set.

Child Welfare Information Service changes its name

Social Legislation Information Service, Inc., is the new name of the non-profit association that was formerly called the Child Welfare Information Service, Inc. The organization has not changed its policy, says Bernard Locker, executive director, but has selected the

new name because it describes more accurately and completely its present program of reporting congressional and Federal action in the broad fields of health, education, welfare, housing, employment, and recreation, as contributing to family, child, and community well-being. The bulletin issued by the association is now called the Social Legislation Bulletin.

The address of the Social Legislation Information Service is 930 F Street N.W., Washington 4, D. C.

State committees on children and youth

GEORGIA

The Georgia Citizens Council has just issued its annual report for the year ending June 30, 1946, under the title, "Georgia's Human Resources." The accomplishments of the council in the youth field as noted in this report include the following:

Improved opportunities for youth, as a result of establishment of a number of youth forums, enactment of a 16-year child-labor law (see *The Child* for March 1946), teen-age center programs, inauguration of full-time recreation programs in a number of cities, sponsoring of training opportunities for volunteer and paid workers in connection with children and youth programs, and gaining of public support for sex education. The council has undertaken to stimulate interest in community programs through the broadcasting of a number of round-table discussions and a series of dramatizations prepared by the council staff.

MARYLAND

Maryland's State-wide commission on youth services has completed its first study, "Youth and the Juvenile Court in Baltimore County," based on an analysis of the docket petitions and other data for the year ended May 31, 1946.

MICHIGAN

Working cooperatively with the Michigan State Police, the Michigan Youth Guidance Commission has prepared a comprehensive practical man-

ual on law enforcement entitled, "Michigan Juvenile Laws for Police Officers."

NEW YORK

"Prevention in Action," a publication of the New York State Youth Commission, presents a report of the activities of the commission during the first year of its operation and reviews some of the significant recent contributions made by other State agencies in the field of juvenile delinquency.

The Youth Commission Act provides for financial assistance to county- and city-sponsored youth bureaus and to county-, city-, village-, and town-sponsored education projects approved by the commission.

During the first year of operation 208 municipally sponsored State-assisted projects were approved by the commission for operation in up-State New York. Approved project applications call for the expenditure of \$894,861.89, of which \$328,913.33 will be returned to sponsoring municipalities in the form of State aid.

As of July 1, 1946, three local youth bureaus were at work in the county of Erie and in the cities of Cortland and Hudson, each of which has a full-time representative advisory committee and executive secretary. Their annual budgets amount to \$75,000, of which \$37,500 will be reimbursed in the form of State aid granted through the commission. The general pattern outlined for youth bureaus is one of study, planning, coordination, and subsidy of new or existing youth services.

The determination of why substantial numbers of youth cannot be reached by organized recreation programs and what can be done about it in a given municipality is recognized as a legitimate youth-bureau undertaking.

Of the approved projects 201 were recreation projects. The first of these plans was approved on August 7, 1945, for the village of Catskill. An analysis of 148 of these projects indicated wide variation in their administrative plans and program content. The majority of them were approved on the basis of a year-round program—the others for summer programs only.

Many communities, particularly the smaller ones, are attempting to organize community recreation programs for the first time. In a majority of these cases

support has come through widespread public interest and through backing by citizen groups and individuals. Practically all communities have made budgetary provisions for leadership, either within the youth-commission project or from other financial sources. The commission has encouraged the employment of qualified leaders, and a number of municipalities have set high standards of qualifications with correspondingly high salary schedules. In many localities the pattern of community integration for recreation services by various agencies and individuals follows closely the plan of the youth commission for coordinated community effort in solving youth problems. State aid amounting to more than \$272,000 has encouraged the expenditure for community recreation services of more than three-quarters of a million dollars throughout the State.

Four educational projects have been approved by the commission. These projects call for an expenditure of \$38,000, of which \$19,000 will be returned to sponsoring municipalities in the form of State aid. According to the law the commission can consider only project applications submitted by municipalities (counties, cities, towns, and villages) and can provide State aid for municipal expenditures only, thereby excluding school-sponsored projects. Generally, municipalities have been unwilling to expend their funds for services that they believe should be financed out of funds appropriated for education purposes.

Two of the educational projects approved by the commission are not yet in operation because of lack of professionally trained and qualified personnel—the child-guidance clinics sponsored by Oneida County and by the City of Rochester. The Oneida County clinic will serve the various school systems throughout the county. The Rochester clinic will serve one of the education units of the city by (1) diagnosing and treating maladjusted students and (2) consulting with teachers and other personnel for the purpose of assisting them in locating vulnerable children.

The education division of the commission is placing major emphasis on the unique responsibilities of the schools in the following fields: (1) Discovery

of maladjusted children; (2) leadership in treatment of maladjustments—both academic and social; (3) enrichment of curriculum and individualization of instruction to reduce academic maladjustments; (4) instruction in mental hygiene for pupils; (5) instruction in mental hygiene and child development for newlyweds and parents; (6) in-service training programs for teachers; (7) local leadership for improvement of conditions affecting young people.

Responsibility for the administration of the program for daytime care of children of working mothers (formerly carried by the State War Council) was transferred to the commission as of April 1, 1946, on an experimental basis for a year, during which the whole problem is to be evaluated and recommendations made for its permanent disposition. In June 1946, 94 centers in up-State communities were giving care to 2,913 children, and 90 centers in New York City were caring for 4,593 children. The New York State Federation of Growers and Processors Associations, Inc., has contracted with the commission to operate in 1946 up to 27 centers in 16 counties and to care for 790 children of migrant workers, with State aid.

This report outlines the contribution that local police departments can render in connection with an effective program for the prevention of juvenile delinquency, and ways in which such departments may be of service. An analysis is also given of crime and delinquency trends in New York City and in up-State New York, with special reference to the 16-to-21-year age groups.

MISSISSIPPI

The Governor has appointed eight members of the Mississippi Children's Code Commission, which was authorized by the 1946 legislature. A ninth member is to be appointed.

The chairman of the committee is J. O. Snowden, superintendent of the Mississippi Children's Home Society, Jackson, Miss. Miss Catherine Bass of the State department of public welfare will serve as legal research consultant. The State board of health and the State department of education have been asked to assign staff members to aid in

the promotional work of the commission.

The membership of the commission includes two State legislators and the heads of the State welfare, health, and education departments and of the State eleemosynary board. Two nonofficial members were appointed, one of whom is the chairman, and a third is to be appointed.

The members of the 1945 commission, which was broadly representative of the legislature, State departments, State organizations, and private agencies, have been asked to serve the new commission in an advisory and supervisory capacity under the title of the Mississippi Committee on Children and Youth.

Reprints available

From time to time the Children's Bureau makes available material published outside the Bureau. Some of this material, in the field of social service, is listed below. The supply of these reprints is extremely limited, but single copies may be had from the Bureau without charge until the supply is exhausted.

Juvenile and Domestic Relations Court. By Genevieve Gabower. Social Work Year Book, 1945.

Babies Have Their Rights. By Ruth Carson. Collier's Magazine, December 22, 1945.

Physicians and Adoptions of Babies. Journal of the American Medical Association, July 28, 1945.

The Adolescent Unmarried Mother. By Maud Morlock. Practical Home Economics, May 1946.

To help Colombia's crippled children

The sum of 150,000 pesos has been raised in Colombia by an association of business and professional men as a step toward establishing a crippled children's clinic in Bogota. The clinic, which will bear the name, "Franklin D. Roosevelt," is planned not only to correct crippling conditions in children but to provide vocational training for the children that will prepare them to be self-supporting.

HOUSEHOLD EMPLOYMENT OF HIGH-SCHOOL GIRLS: Standards for high-school girls, parents, and employers. Occupational Pamphlet Series, No. 3. Oakland Public Schools, Department of Occupational Adjustment, Oakland, Calif. 1946. 12 pp.

Although this booklet was prepared especially for use in the community where it was written, it should be of help to other communities that wish to safeguard the interest of high-school girls working in households and, of their employers.

The material is sponsored by a committee representing such organizations in the city of Oakland and Alameda County, Calif., as the Y. W. C. A., the council of social agencies, the parent-teacher association, Catholic Social Service, a county court, and the United States Employment Service, as well as the Oakland public-school system, which published the booklet.

Besides certain legal restrictions applicable locally, a number of voluntary standards are listed which if followed should lead to more satisfaction for the girl workers, their parents, and their employers.

For example, the booklet urges that before a high-school girl enters household employment there should be a definite understanding regarding such things as home privileges, working and living conditions, and wages and hours. The duties and responsibilities of the employer and of the girl worker should be clearly understood by each.

If the employer asks that the girl have a physical examination or that she present a physician's certificate of health, consent of the girl's parents should be obtained and the employer should pay any expenses involved.

The employer should accept responsibility for the girl's regular attendance at school, and if the girl is attending full-time school she should not be given regular duties to be done before school, in the morning.

If a girl is to be left alone in care of children, certain specific safeguards should be provided, which are listed.

In order to help employers know what is suitable pay for these girl workers, the booklet quotes the wages prevailing in Oakland in the spring of 1946. For example, a girl living in the employer's home, but working elsewhere and only helping with dinner dishes and with child care, received only room and board; the girl living in her own home and working in the employer's home after school and Saturdays, helping with the housework and with child care, received 50 cents an hour.

Hope Castagnola

WORK EXPERIENCE IN SECONDARY EDUCATION; a study of part-time school and work programs, by Harold J. Dillon. National Child Labor Committee, New York, 1946. 96 pp.

This report is based on visits made by the author in 1945 to 11 cities in different parts of the country, where well-organized school-work programs were in operation—cities in which students were released from part of their school day for paid work, but were at the same time under the guidance and supervision of school personnel. Most of the programs studied were based on the 4-4 plan, that is, 4 hours of school and 4 hours of work. The object of the study as stated was to appraise this type of part-time work as an educational experience for secondary school students, organization of the programs; and administrative set-ups and methods used in selecting, placing, supervising, and

The report describes the origin and guiding the students. Other aspects of the programs discussed in the report are the granting of school credit for work; the school's control over working conditions such as hours, night work and illegal employment; the extent to which work experience and classroom studies were correlated, and the effect of work on scholarship. Appraisals of these work-experience programs by school principles, employers, labor groups, parents, and the students themselves, are included as the final section of the report.

In summing up, the report says: "The

evidence obtained in this study of work-experience programs organized during the war years suggests: (1) That such programs, if they are to be continued, will need careful evaluation and the adoption of definite procedures and safeguards that could not always be provided in the many rapidly developed, and often large scale programs that were set up under wartime pressures; and (2) that such programs, though they should not be regarded as the solution of all the problems in secondary education, may become one of the many resources that will be developed to provide more meaningful educational experience for secondary-school students than the usual school curriculum now does." Also, "Continuance or extension of work-study programs must inevitably depend on the economic conditions prevailing at any given time."

Caroline E. Legg

Editor's note: The Children's Bureau and the Office of Education have been conducting a joint study of school-work programs based on a Nation-wide mail inquiry in the spring of 1945 supplemented by visits to selected cities. A report of the findings of this joint project is in preparation.

THE COMMON SENSE BOOK OF BABY AND CHILD CARE, by Benjamin Spock, M. D. Duell, Sloan, and Pearce, New York, 1945. 527 pp. Also published in a pocket edition, under the title, *The Pocket Book of Baby and Child Care*. Pocket Books, New York, 1946. 520 pp. 25 cents.

This is really a book of *uncommon* good sense. Everyone reading it—and this will be nurses, teachers, social workers, clergymen, and any others who associate with children, as well as parents—will get the feeling that the doctor is talking to him. The print doesn't get between the author and his readers. And Dr. Spock has the art of plain talk down so cold (to use one of the idioms that make his writing completely informal) that people who don't ordinarily find reading much of a pleasure will enjoy looking up the things that have been puzzling them.

To cover the whole period of infancy and childhood is a large order, but, everything from diapers to divorce and from dawdling to drowning is touched on. Families who are out of reach of

a doctor will be particularly benefited by such sections as those on illnesses and formulas. But no one who picks it up, whether to read a paragraph here and there, or to read it from cover to cover, will lay it down without having gained something of the reassurance so vital to ability to deal with children.

Marion L. Faegre

EIGHT YEARS OF PUBLIC HEALTH WORK; Jones County, Miss., 1937-1944. Commonwealth Fund, New York, 1946. 80 pp. 50 cents.

Although this report was prepared primarily to inform Mississippians about the program of the Jones County Health Department, it should be of interest to other public-health departments and public-health personnel, for it is concerned with the growth and development of a typical county health unit.

The report states that the maternal mortality rate among whites was reduced from 5.2 deaths per 1,000 live births for the 3-year period 1935-37 to 2.3 in 1944; the Negro, from 9.6 to 7.4. Also, in 1944, 67 percent of all births to whites occurred in hospitals, but only 19 percent of Negro births.

Evaluation of the service by the health-department staff is evident throughout the report, and the failures and shortcomings are frankly described along with the gratifying accomplishments. In most instances the reason for unsatisfactory results has been determined and changes instituted or suggested to correct them.

Clara E. Hayes, M. D.

JOB-PLACEMENT

(Continued from page 91)

briefly, counseling with regard to employment; referral to suitable jobs; follow-up service after placement; referral to educational, health, social service, and other specialized agencies in the community for needed services; aid in the development of employment and training opportunities for young people; and participation as a placement agency in broad social and economic planning in the community.

3. These services should be of high

quality. To this end, it is essential that staff members counseling young people be selected on a basis of merit and be skilled in the basic professional techniques of counseling, and that effective working relationships be developed between placement offices, schools, and other community agencies.

4. These basic placement services to young people should be provided through an organized placement office in all localities where a labor exchange is needed to bring together job seekers and employers in the immediate community, according to accepted criteria for establishing such an office.

5. In localities that do not have an organized placement office—and these are predominantly in rural areas—there should be cooperative action to give placement assistance to young people by extending in a coordinated way the related services of local school and other existing agencies serving young people.

6. For adequate placement assistance to young people migrating from their home communities, the agencies giving placement service in localities from which they come and in cities to which they go should develop cooperative relationships including interchange of information.

7. Placement service for young people should promote desirable working conditions for them by making placements in accordance with legal and otherwise acceptable labor standards and by calling the attention of employers, community agencies, and the public to the existence of undesirable practices in the employment of young workers and the steps that might be taken to improve working conditions for young people in the community.

8. The development of successful placement services for young workers should be accompanied by the growth of guidance programs in the schools and other institutions which applicants leave to go to work.

Copies of the full Statement of Principles of Placement Services for Young People (4 pp. mimeographed) can be obtained from the Child Labor and Youth Employment Branch, Division of Labor Standards, U. S. Department of Labor, Washington 25, D. C.

Reprints available on request

Oct. 28-Nov. 30—UNESCO Month will be celebrated at the time the General Conference of UNESCO is in session. The first meeting of the General Conference is expected to be held this year in Paris, in early November. Further information from Mass Media Branch, Division of Public Liaison, Department of State, Washington 25.

Nov. 10-16—Children's Book Week. Further information from Children's Book Council, 62 West 45th Street, New York 19.

Nov. 12-14—American Public Health Association. Seventy-fourth annual meeting. Cleveland.

Nov. 20-22—National Conference on the Control of Juvenile Delinquency. Washington. Postponed from Oct. 21-23.

Nov. 25-27—The National Society for the Prevention of Blindness. New York. Of interest to all who are directly or indirectly concerned with eye health and safety.

Dec. 2-4—National Conference on Labor Legislation. Washington.

Dec. 2-6—Association of State and Territorial Health Officers. Washington.

Dec. 5-8—American Public Welfare Association. Baltimore. Permanent headquarters: 1313 East Sixtieth Street, Chicago 37.

Dec. 9-11—National Commission on Children and Youth. At the Children's Bureau. Washington.

Little Anne, on our November cover, is happily occupied with her painting. If more children had pleasant occupations to keep them busy, fewer would have personality problems. The picture is a Library of Congress photograph by Marjory Collins for OWI.

Other credits:

Page 82 through 85, photographs by courtesy of The Johns Hopkins Hospital.

Page 86, Library of Congress photograph by Carl Mydans for Farm Security Administration.

Page 87, Library of Congress photograph.

Page 89, Photograph by Allen for Florida State Board of Health.

TO SAVE PREMATURE BABIES

We have been slow in learning to save the lives of premature babies—those weak, underdeveloped babies that now die in such large numbers a short time after they are born.

During the last decade or so, however, we have learned a great deal from the research and experience of many workers. We know more about how to feed these babies, more about how to keep them warm, and more about how to keep them from picking up infections.

And we have learned that it is not enough to give the baby even the best medical and nursing care in the hospital, if it merely keeps him alive during his hospital stay; that we must look ahead to the baby's future in his own home and do what is needed in order that he may continue to receive medical and nursing care in suitable home surroundings.

Although many problems about premature babies still remain to be solved, we now have knowledge and skill that could save thousands of these babies' lives every year.

But to apply this knowledge and skill in even a restricted locality calls for much special planning, equipment, and personnel. It calls for nurseries planned especially for premature babies. It requires doctors expert in the care of these babies, so that such a doctor can be on call at all times. It

calls for many specially trained hospital nurses, because premature babies need twice as much nursing care as full-term babies. The nurses are needed, not only to give continuous care to the baby night and day while he is in the hospital, but to teach the baby's mother and father how to care for him after he goes home.

And then it requires public-health nurses to visit the home before and after the baby is discharged from the hospital, to continue the instruction and to help the parents in following the doctor's recommendations; for in many homes it is not easy to give proper care to one of these small babies.

And it calls for medical-social workers to advise with the doctor and public-health nurse and when possible to visit the parents at home before the baby is discharged from the hospital, to help make the home situation suitable for a premature baby to live in, and to help parents with personal and economic problems that will affect their ability to provide the care he needs.

A program at the Johns Hopkins Hospital for saving premature babies born at home, or in hospitals not prepared to care for them, is described in this issue of *The Child* by Dr. Janet Hardy. This program has been going on less than a year, and so its results cannot yet be judged. But there is no question of the need for such programs. It is estimated that 5 per-

cent of all the babies born alive in the United States are born prematurely. And that amounts to 150,000 babies a year. Though research into the causes of premature birth and improved methods of care of the mother to reduce this number of such births are urgently needed, we also need many more planned programs for the care of these babies, spread widely throughout the country to save a greatly increased proportion of those that are born now.

If these plans are to succeed we shall need many more pediatricians and nurses with special knowledge and skill in the field of caring for premature babies. These will be needed to take major responsibility for the care of these babies and to teach medical and nursing students so that the general practitioners and the nurses of the immediate future will be better able to help save premature babies.

While we are planning to save these babies' lives after they are born, we must not forget that in many cases good prenatal care of the mother will keep the baby from being born too soon. We need to learn much more about what causes premature birth and how to prevent it. But in the meantime we must keep on trying to save the many babies that are born prematurely.

Maetha M. Elean
Associate Chief, Children's Bureau

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CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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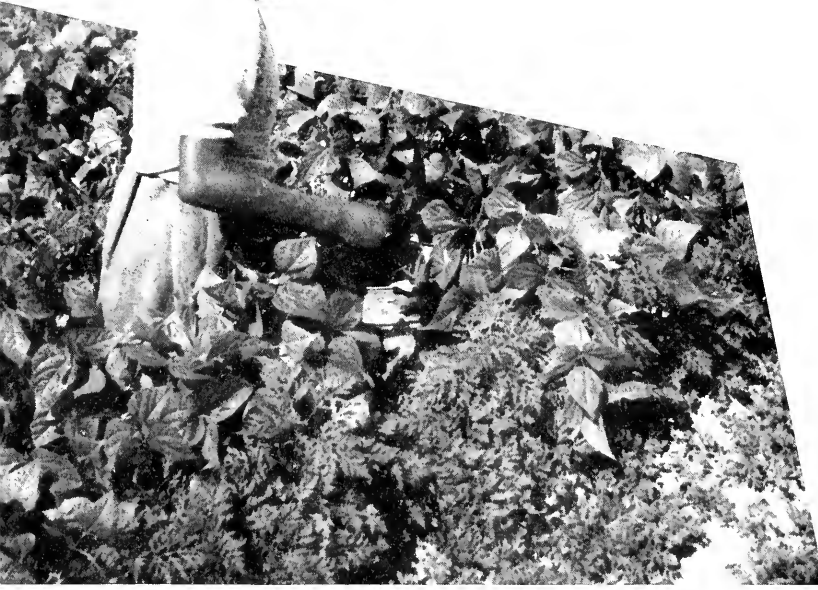
DECEMBER 1946

CHILD



CHILDREN IN THE EVERGLADES

A 9-year-old girl picking beans. Even the young children of migratory workers put in long hours of hard work in the fields



EACH WINTER an army of migratory workers who have harvested the fruit and vegetable crops of the Atlantic seaboard assemble in Florida to work in the winter gardens. Here in the fertile, black earth of drained swamplands out-of-season vegetables of every kind are grown for city markets a thousand miles or more away. In 1946 approximately 40,000 domestic laborers, most of them with wives and children, and 8,000 laborers without families, brought under contract from Jamaica, the Bahama Islands, and Barbados, were in Florida for work on the winter crops.

The West Indians fare better than the domestic laborers in every respect. They are brought into the United States under an international agreement which guarantees them certain living and working conditions. They are guaranteed housing, medical services at all times, transportation to the place of work, and a minimum weekly wage which must be paid even when they are unable to work because of weather conditions, crop failure, or any other emergency. The foreign laborer is

home of a migrant packing-house worker. The only bed for six people stands in the corner



Migrant packing-house workers. "Enough land to set up living quarters rents for \$5 a month"



given a medical examination before he comes to this country and is under medical care for as long as he is here. He has employment guarantees for the period he is in this country, and can count on his weekly wage without fear of what his family will face between harvests. He is carried to the next job without uncertainty or expense to himself.

The expense of maintaining these services in accordance with international agreements is paid by the Federal Government. But under the act appropriating money for these services the money cannot be used for transporting any workers except the foreign ones from one county to another without the consent of the county agent. And no funds can be used, directly or indirectly, to regulate wages, housing, or hours of work for our domestic migrant workers. The American migrant therefore usually travels, with his wife and children, at his own expense and at his own risk. Families are crowded into trucks that are dangerously out of repair. The worker goes from one job to another, frequently finding no work at all as a result of crop failure or such an oversupply of labor that he can barely earn a day's food with 12 hours of work. The families live where they can, in barns, ditches, or growers' camps. Sometimes domestic migrants and their wives and children are put out of good camps to make room for foreign workers, who are guaranteed standard housing.

A few thousand domestic laborers are housed in federally operated camps



The Migratory Labor Hospital at Belle Glade offers the only medical service available to many thousand agricultural workers



The usual living conditions among migratory vegetable pickers and agricultural workers



Migratory agricultural workers living in houses that had been condemned by the board of health





Metal shelters house the families of agricultural and packing-house workers at the Osceola migratory labor camp



The Federally operated migratory labor camps provide laundry rooms and other facilities essential to health and decent living

The Assembly building at the Okeechobee migratory labor camp. It is always open for meetings, reading, and recreation



originally built by the Farm Security Administration, United States Department of Agriculture, and not needed to house the imported workers. Here they have the rudiments of civilized living—garbage disposal, toilet and laundry facilities, health services, and some form of recreation. But even here the American worker is not as well off as the West Indian, since he has no guarantee of employment. Moreover, in the Everglades area, not more than one American family out of five lives under these conditions.

The following excerpts from reports to the Children's Bureau describe what must be considered the "normal" living conditions of American migratory laborers in the Everglades. And the conditions are not peculiar to the Everglades; they are found wherever the migratory laborer goes, in practically every State in the Union.

"This is a row of about 12 unscreened, small, one-room shacks not more than 2 feet apart. Water is obtained from spigots outside the shacks, and there is one outside privy for the entire group. The camp is a desolate-looking place, with uncollected garbage and puddles of water all over. At the end of the street is a store. One of the men said that there are 10 children of school age in the camp. There are 4 children under school age.

* * *

"Rows of shacks where often 6 or 8 people are housed in a space 8 by 10 feet. Here babies are born, usually without attendants. In a row of rooms so loosely constructed that one looks through the cracks of boards into the next room and where every breath is heard, children are exposed to the filthy language of drunken adults; women "entertain" their men; babies are left in the care of old women too stiff to kneel down to pick beans or, worse still, just left."

The American families living under these conditions may have been farm owners a few years ago, or respectable farm tenants. They now have no stability whatever. The children have never known anything but squalor. They attend school so irregularly that many of them never get beyond the first grade. They have little or no contact with the communities in which they live.

and none of the usual community services such as schools, health service, churches. They move up and down the country and are outcasts wherever they go. They are denied even the minimum helps which other governments insist that the United States provide for their nationals who work here.

For some time to come we must expect the number of migratory agricultural laborers to increase, as more and more land is cultivated to produce fruit and vegetables to meet the growing demand for them. Also, as the mechanization of the cotton-growing industry continues, more and more sharecroppers and farm laborers are becoming migratory workers.

And unless the conditions under which they live are materially altered, these families can become an infected stream carrying ignorance, disease, and crime into every community in the land. The damaged and handicapped adults which the children will grow into will be citizens of the United States with a claim on the Nation and a voice in national affairs. This is a serious problem which must be faced and solved soon, for a democracy cannot live with such a poison in its roots.

"The solution of the migratory labor problem is not simple. It requires legislation that will better the wages and employment conditions of migratory workers, keep their young children out of the fields and get them into the schools, protect them from accidents both at work and during transportation, regulate the conditions of their recruitment, and improve their living conditions. It requires development of ways to give migratory workers and their families the health, welfare, education, recreation, and other community services that they need. To get such legislation, to provide for its administration, and to achieve the integration of migrant workers into community life requires broad public interest, understanding, and support."—Report of the Committee on Migratory Labor, Thirteenth National Conference on Labor Legislation, held by the Secretary of Labor, December 2-5, 1946, at Washington.



A child getting water from a canal. Cleaner water would have to be hauled from the packing house

A privy used by vegetable pickers. Such unsanitary conditions are common among domestic migratory workers



ONE WORLD FOR HEALTH

MARTHA M. ELIOT, M. D., *Associate Chief, U. S. Children's Bureau, and Vice Chairman, U. S. Delegation, International Health Conference*

EPIDEMICS carry no passports, said Trygve Lie, Secretary General of the United Nations, welcoming the members of the International Health Conference at its opening meeting at New York, June 19. The health of one country, he said, affects the health of neighboring countries and of the world at large. Establishment of a World Health Organization, Mr. Lie went on to say, will be one of the first concrete, constructive steps in the broad and vital program which the United Nations is undertaking on behalf of all mankind.

The International Health Conference was called by the United Nations Economic and Social Council to formulate a charter or constitution for a World Health Organization. The first step was taken toward such an organization a year earlier, at the San Francisco meeting of the Council, when two countries, Brazil and China, jointly introduced a resolution calling for an International Health Conference.

Fifty-one nations, members of the United Nations, were represented by delegates. Thirteen other nations, not members of the United Nations, were represented by observers. These included Albania, Austria, Bulgaria, Eire, Finland, Hungary, Iceland, Italy, Portugal, Siam, Sweden, Switzerland, and Transjordan. Afghanistan, Rumania, and Yemen were invited to send observers but were not represented. Observers from the Allied Control Authorities in Germany, Japan, and Korea also attended the conference. Thus all nations of the world except three were represented.

At the first plenary session, under the temporary chairmanship of Dr. Andrija Stampar, Vice Chairman of the Economic and Social Council, the Conference elected Dr. Thomas Parran, chairman of the United States delegation, as its President.

The work of the conference was based on a draft constitution that had been prepared by a Technical Preparatory Committee of Experts meeting in Paris in March 1946.

Five major committees of delegates and advisers to the International Health Conference dealt with the following questions: (1) Scope of activities and function of the proposed World Health Organization; (2) administration and finance; (3) legal matters; (4) relation of World Health Organization to United Nations and other international organizations; and (5) regional arrangements.

The task was a highly technical one. Much of it was legal and involved questions of international policy. Though there were a number of knotty problems to be solved, the work of the conference went forward in a spirit of cooperation and good will.

On July 22, 1946, the constitution of the World Health Organization was approved unanimously by the conference and signed by 61 nations.

The delegates of a few nations had full authority to accept the constitution for their governments; a majority of delegates, however, as in the case of the United States, signed subject to later approval or ratification by their governments.

On July 22, the conference also approved and the delegates signed a convention establishing an Interim Commission, consisting of 18 member states, instructing it to prepare for and call the first World Health Assembly. Dr. Fedor Krotkov, Deputy Minister of Public Health of the Union of Socialist Soviet Republics, was elected chairman of the Interim Commission and presided at its first meeting immediately after the adjournment of the conference. Dr. G. B. Chisholm, Deputy Minister of Health of Canada, was elected executive secretary. A secretariat is provided for the Interim Commission. The staff is to prepare the agenda for the first World Health Assembly, negotiate agreements with the United Nations and with other international organizations, such as the International Labor Organization and the Food and Agriculture Organization, and work out plans for assuming certain health activities of UNRRA, the Health Organization of the League of Nations, and the Office International d'Hygiene Publique in Paris. The Interim Commission also has authority to deal with emergency matters that may arise before the first Assembly meets.

Membership in the World Health Organizations is open to all nations. Members of the United Nations and all nations invited to send observers to the

Jimmie, a Churka boy, doesn't like the inoculation the British doctor is giving him, but he's taking it like a man



International Health Conference may join now by signing or otherwise accepting the constitution in accordance with their constitutional processes. All other nations may apply for membership, but a majority vote of the World Health Assembly will be necessary for admission.

The World Health Organization will function through (1) a World Health Assembly to which all member states may send three delegates, (2) an executive board of 18 member states, and (3) a secretariat headed by a director general. The Assembly will meet at least once a year, the board at least twice a year. Policy will be determined by the Assembly. Advisory and technical committees are provided for. In addition to the three central bodies, the constitution of WHO provides for decentralized activity on a geographical basis, including regional committees representing member states in the area and regional offices. The director of a regional office will be appointed by the executive board in agreement with the regional committee.

The functions of WHO and the scope of its activities are very broad. The constitution lists 22 functions, including the coordination of international health work, assistance to governments upon request in strengthening health services, adoption of regulations to prevent the

international spread of disease, the establishment of international statistical and epidemiological services, the promotion of maternal and child health and mental health, the standardization of diagnostic procedures, food and drug control, and health-information service. The scope of activities of WHO will also include medical and public-health education, research, and the study of administrative and social techniques affecting public health and medical care from preventive and curative points of view, including hospital services and social security. Furthermore, this section of the constitution specifically recognizes that the promotion of better nutrition, housing, sanitation, recreation, economic or working conditions, and other aspects of environmental hygiene is a function of WHO.

Under its constitution WHO, though affiliated with UN as a specialized agency, is autonomous and is not limited to action through the United Nations or its Economic and Social Council. However, the scope of activities outlined in the WHO constitution makes it apparent that there must be close cooperation between it and other international organizations. Such cooperation will be assured when satisfactory working agreements are developed with UN, ILO, UNESCO, FAO, and the Social

Commission of the Economic and Social Council.

The International Health Conference did not undertake to discuss the details of the program that will be carried out by WHO. That is the responsibility of the Interim Commission in preparing the agenda for the first World Assembly and for the Assembly itself. The task that WHO must undertake to improve the health of the men, women, and children of the world is very great; the mandate under which it will work is much broader than that of the Health Organization of the League of Nations. The document setting forth this mandate—the charter for world health—can be an instrument for great good among all peoples if it is adequately implemented by the member nations and if the spirit of friendly cooperation in which it was conceived and born pervades and governs action taken under it.

The preamble to the constitution for WHO sets forth certain principles, among which is the following:

“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”

With this ideal few would quarrel. Its attainment will not be easy. But if this concept of what is just and right matures and becomes universally accepted in the field of health, it would lead us far along the pathway to the attainment of many other human rights for which we strive, including the right to live our lives in freedom and in peace. The World Health Organization can be a potential force in the struggle for world peace and for the universal recognition of the fundamental dignity of all human beings.

Based on “The World Health Organization,” by Martha M. Eliot, M. D., published in the *Radcliffe Quarterly*, November 1946.

WORLD HEALTH ORGANIZATION'S BASIC PRINCIPLES

As “basic to the happiness, harmonious relations, and security of all peoples,” the following nine principles are listed in the preamble to the constitution of the World Health Organization:

Health is a state of complete physical, mental, and social well-being and not

(Continued on page 111)

An UNRRA public-health nurse is instructing a Chinese public-health nurse in Shanghai at a maternal and child-health clinic



CHILD-HEALTH CLINIC

FULL-TIME HEALTH DEPARTMENT

CHILD-WELFARE OFFICE

RECREATION PROGRAM

HEALTH SERVICE FOR SCHOOL-AGE CHILD

SERVICES FOR DELINQUENTS

CHILD-GUIDANCE CLINIC

in 1947

PUBLIC-HEALTH NURSING

what will Y
for children





MATERNITY CLINIC

HOSPITAL CARE

DAY-CARE CENTERS

CHI

FOSTER-HOME CARE

SCHOOL LUNCHES

ADOPTION SERVICE

**U do to bring these services
to *YOUR* community?**

RURAL SCHOOLS CHALLENGE PUBLIC HEALTH

JESSIE M. BIERMAN, M. D., *Chief, Bureau of Maternal and Child Health, California State Department of Public Health*

THE PURPOSE of these remarks is not to say that the health of the school-age child is important, nor to render another opinion on what health services in the schools should include. These things have been expertly said many times. Rather, an attempt will be made to state very briefly the extent and nature of some of the problems facing the schools and public health in the vast rural areas of the country; to venture some opinions as to why more has not been accomplished in the past; to state a few proposals for future action, and to admonish public-health workers to accept the challenge of this rural job.

The School Health Section of the American Public Health Association has among its responsibilities that of bringing to the attention of public-health officials the problems in this field; of stimulating ourselves to accept responsibility for those functions which are clearly ours; and the fostering of better understanding between public-health and school officials.

On the whole, we in public health have contributed relatively little toward solving the problems which underlie the frequently heard criticisms of existing school-health programs in the cities, and not much more toward the provision of really adequate services for the millions of children living in rural areas. To a considerable extent, health programs in the larger city school systems have been developed by the school authorities. In rural areas the problem has been too complex and the expense too great for the schools to handle alone, even if it were desirable.

The problems of rural school health are a combination of the difficulties facing the schools and facing public health everywhere, plus the special health problems of rural communities.

According to the latest figures available,¹ more than 11,000,000 children are enrolled in public schools in rural communities and towns and villages of less than 10,000 population. With the migration to urban industrial centers during the war, the number undoubtedly

decreased somewhat, but still approximately half of our children live and attend school in predominantly rural sections, where the average annual expenditure per pupil enrolled is less than 70 percent of that for city schools, and the per-pupil value of school property and the average salaries of the instructional staff are about half those in cities. There are still over 100,000 one-room schools.² Serious teacher shortages and lag in school-plant construction are problems affecting both rural and urban areas. The Interbureau Committee on Postwar Programs, formed under the auspices of the Department of Agriculture, has summed up very well the salient facts about health in the rural sections of the country today in its publication, "Better Health for Rural America."³

The great improvements in health which have been brought about in cities as a result of improved sanitation and advances in medical science have to a considerable extent been denied persons living in rural areas. Death rates from the preventable diseases such as typhoid fever, diphtheria, malaria, and pellagra are higher. Maternal and infant mortality rates are higher. Contrary to the experience in the last war, farm youth showed considerably higher rejection rates for military service in World War II.⁴

There are indications that the maldistribution of physicians, dentists, and nurses, apparent before the war, is becoming more marked as many former country doctors are returning from service to practice in the cities. The situation with regard to the services of specialists to persons living in rural areas is even worse than for general practitioners. As an example, there are only 100 pediatricians to serve the 20,000,000 children living in small communities.⁵

Presented at the seventy-fourth annual meeting of the American Public Health Association, before the joint session of the sections on maternal and child health, public-health nursing, dental health, and school health. Cleveland, November 14, 1946.

The results of the Academy of Pediatrics survey on child-health facilities, now in progress, should give us among other facts, specific information concerning the inadequacies of health resources for children living outside cities. The lack of hospital and convalescent facilities in rural areas is well recognized, and here, too, more facts will be available as a result of the current hospital surveys.

The health situation in small towns throughout the country is, in some respects, even less favorable than in the open country, as these areas have lost some of the advantages of rural life and yet have not gained the modern scientific advantages of the cities.

The low incomes of the rural population, the larger families, the sparsity of population, the longer distances, the greater costs of education, of health services, and of medical care, the poorer health status of the people, and the resistance to change due to lack of education and experience of good services, form a number of interrelated vicious circles. Many agencies are presently concerned with attacking them at one or more points.

The interest with which the Emerson report⁶ has been received and the earnestness with which its recommendations have been considered by public-health leaders in all parts of the country is indicative of the concern of the public-health professions. There are hopeful indications that some definite steps will soon be taken in a substantial number of States to extend organized health services to many of the approximately 1,400 rural counties not now served.

This is encouraging to all those interested in the welfare of rural children, not only because of the improvement in the general level of health which will result, but because included among the six basic functions of a local health department enunciated in the report is the clear statement of responsibility for the "hygiene of maternity, infancy, and childhood, including supervision of the health of the school child."⁷

But we all know that this statement

of intent is not going to assure that the newly created health departments will take the desired leadership in the field of school health any more than many pious statements in the past have brought this about in the many existing health departments including rural areas in their jurisdictions.

Legal obstacles, questions of jurisdiction between the schools and the health department, lack of a real understanding of cooperative techniques and of skill in their use, attempts to apply methods found successful in city schools but not applicable to rural schools, as well as lack of treatment facilities and insufficient funds and personnel, have stood in the way of progress.

It is not so much that we don't know what to do in school health, but more that we don't know how to do it in a somewhat complicated interdepartmental setting.

Too often our idea of cooperation with the schools has consisted merely of an arbitration of difficulties after they occur, rather than any real attempt to arrive at a common understanding of goals and agreement on the steps necessary to achieve them.

We have not taken the time to become really acquainted with the school administrator and the teachers and to learn from them more about the modern philosophy of education, and the place which they believe health services and health education have in the schools.

When we do, some of us will undoubtedly be surprised to find them ahead of us in their ability to see the child and all of his needs as a whole. They will tell us what they think of the educational value of rendering services in separate and unrelated segments—an immunization drive at one time, discovery of physical defects by mass examination at another, talks on sex education because it happens to be social-hygiene week.

Too often we have offered specific and unrelated services to the schools when we have some spare time or in connection with a drive of one kind or another which may bear no relation to the planned program of the schools, and if our offers were not eagerly accepted we have talked of lack of cooperation.

The schools tell us that the necessity for weaving health education and services into the fabric of the child's life in



About half our children attend school in rural sections where expenditure per pupil is 70 percent of that for city schools

school and in the home is one of the most difficult things for the average public-health worker to appreciate, and it is here that teachers can be of the greatest help to us. On the other hand, school personnel need our help to gain an increasingly better understanding of the scientific content of health. In learning to think, plan, and work together, we shall break down the barriers which our respective professional jargons have helped to build between us. We shall learn that there is nothing so mysterious about the "educational method," and they'll learn that most of the sonorous Latin phrases of medicine are just hard ways of saying simple things.

It is largely because of this lack of fundamental understanding that the schools, in their desire to get something done, have wherever possible employed their own physicians, dentists, and nurses. That is not the only solution, nor is it the best solution to the problem. The modern health department has skills and resources, and potential resources, that the schools need and cannot duplicate. By no means the least of these resources is the machinery and the know-how for following up on the correction of all the defects discovered. A way must be found to make all these services and resources fully available to the child of school age.

It is for these reasons that the committee on rural-school health of the school health section has recommended that an administrative study be under-

taken in a rural county (1) to work out such problems as ways of joint planning and cooperative action between schools, health educators, physicians, and other community groups, and (2) to determine the specific responsibilities (a) of State and local health-department personnel, including the health officer, special consultants, staff physicians, dentists and dental hygienists, public-health nurses, sanitarians, and health educators; (b) of State, county, and local school personnel, including administrators, supervisors, health co-ordinators, teachers, and school-bus drivers; (3) to find the most effective methods for utilizing the services of practicing physicians and dentists in the community, and of the services of specialists in medical centers; (4) to develop methods for making full use of the expanding crippled children's services that are developing in every State; of hearing- and sight-conservation, rheumatic-fever, and tuberculosis programs; (5) to determine effective means for correlating health services with health education; (6) to determine effective means for bringing modern concepts of emotional health into the program; (7) to learn how the health-education program in the schools can be made a part of community education so that together they may serve as effective instruments for raising the level of public understanding of health needs and practices in the community; (8) to work out effective means for giving in-service training to workers for carrying

their own responsibilities; and (9) to make suggestions as to needed pre-service training for personnel to serve rural schools.

The prospectus for this rural-school health project outlines a 5-year study, the results of which the committee hopes can be written up as a practical handbook for every rural health worker, school administrator, and teacher.

But there are many things we know how to do now. There would seem to be no good reason why State departments of education and health in every State should not set up joint committees to study problems affecting the health of children of school age. In a number of States such committees have long been in existence and have proven very successful in bringing about better understanding between the departments and better services for children. Similar committees on the local level should be developed, now.

Among the specific functions of such committees could be study of present laws affecting school health with a view to getting the antiquated, restrictive, and meaningless laws overhauled at the earliest opportunity. Laws or regulations concerning the apportionment of school funds on the basis of average daily attendance are due for reconsideration in favor of some method which does not adversely affect the health of children. Publications on health, prepared and issued under the joint auspices of the two departments, are better received by the schools than those issued by health departments.

As a result of the additional Federal funds being made available to the States through the Children's Bureau, it should be possible for all State health departments to employ one or more persons—pediatricians, public-health nurses, health educators—whose primary responsibility it is to inform themselves on the modern concepts of school health and to become experts in the various aspects of this specialty of public health. They could provide leadership, which is so badly needed, and could be of inestimable help to the staffs of existing and newly established local health departments. It should also be possible to develop, if only in one county or even one school, a cooperative program which incorporates the best of modern health practice and education.



A way must be found to make available to the schools the skills and resources of the modern health department

Such a setting would serve as a testing ground and as a field training center. There are many other ways in which real progress can be made now.

No discussion on any phase of public health activity is complete without recognition of the need for a tremendous increase in personnel and for much better trained personnel to do the job that lies ahead.

I am told that school administrators believe it will be 50 to 75 years, at the rate we have been going, before health departments will have sufficient trained personnel to meet the community health needs of the entire country, and even longer before the public schools will get the kind of highly specialized services recommended by national committees.

This job will not wait the many years which will be required for a sufficient number of young men and women to drift into public health after having been trained primarily for other careers, in medicine, dentistry, nursing, and the allied fields. Some radical changes are urgently needed in the recruiting and training and compensation of personnel for public health. Present shortages of personnel and facilities make it urgent that all available resources be utilized with utmost efficiency.

Not all public officials, in common with many others in the country, have begun to accept the kind of expansion which calls for imagination and bold-

ness. Marquis Childs in his newspaper column recently commented on the great postwar dilemma in which we find ourselves as a result of shortages of all kinds, overcrowding, and soaring prices. His words apply to the dilemma in which we in public health find ourselves: "Yet in face of this need, we seem to be overcome with a kind of paralysis of mind. We are thinking still in terms of the economy of 1939 and 1940 . . . all the potentialities are here. It is the promised land just over the horizon. Yet we stand, like timid children, chained to the past and fearful of the future."

In the field of rural school health, there is not much to look back to, and there is little to fear in the future except the results of doing nothing. The schools and millions of children are depending upon us in public health to accept the challenge. The challenge lies not only in doing a job that has got to be done, but in the opportunity to move forward to new achievements, unfettered by the outmoded rituals and traditions of the past.

¹ Blose, David T.: *Statistics of Schools in Urban and Rural Areas, 1941-42*. U. S. Office of Education, Circular No. 231, Washington, D. C., 1945.

² Same.

³ U. S. Department of Agriculture, Interbureau Committee on Postwar Programs; *Better Health for Rural America*, p. 1. Washington, 1945.

⁴ Same, p. 2.

⁵ Health Needs of School Age Children and Recommendation for Implementation: Report of Interdepartmental Subcommittee, *School Life*, November, 1945, pp. 7-14. U. S. Office of Education.

⁶ Emerson, Haven. *Local Health Units for the Nation*. New York, Commonwealth Fund, 1945.

⁷ Same, p. 2.

THE CONSULTANT PEDIATRICIAN

Many State agencies administering maternal and child-health or crippled children's programs under the Social Security Act are planning to add consultant pediatricians to their staffs, or already have them. Such State agencies may find of interest the following statement from *The Lancet*, London, June 8, 1946, p. 865.

The British Paediatric Association has made the following suggestions intended to help centers (other than the main undergraduate teaching schools) which may be considering the appointment of a consultant pediatrician.

Qualifications

A consultant pediatrician should have received his pediatric training at an approved children's hospital or children's department of a hospital.

He should have at least 5 years' training and experience after qualification. One, preferably the first, year of this period of training should be spent in an appointment or appointments in adult medicine or surgery. Three years should be devoted to pediatrics, using this term in its widest sense to include all medical work among healthy and sick children. One year should have been spent working at some allied subject such as work in a maternity unit, infectious diseases, psychiatric children's department, laboratory work, or travel abroad.

He should be a member or fellow of one of the Royal Colleges of Physicians or hold an approved higher degree in general medicine; the degree of doctor or surgery is not essential for a higher post of this type.

He should not engage in general practice.

Remuneration

The standards of remuneration should be based upon the assumption that no considerable measure of private practice will be available. In determining these standards for a consultant pediatrician, whether part time or whole time, his services should be valued in the light of the work done and responsibilities assumed. It should be borne in mind that the care of children involves great responsibility.

Traveling expenses in connection with this work, adequate secretarial and office assistance, and time off to attend meetings of learned societies should be provided.

Staff of the Department(s)

In his hospital work he should be afforded adequate medical assistance of the type of medical registrars and house physicians, and these must be taken into account when assessing the requirements and cost of the department. In order that the best nursing services may be available for the children, the senior nursing staff in the children's department should hold the sick children's nurses' certificate.

Duties

He should have general charge of the children's department of the local hospitals, should act as consultant to the local hospital for infectious diseases, should be responsible for the care of the newborn in the local maternity departments, and should also be available as a consultant for long-stay country hospitals, convalescent homes, and residential schools for defective children. He should be consultant to the school health service, the local welfare clinics, the tuberculosis service as applied to children, and any other service for children for which the local authority is responsible; he should be available for domiciliary consultations, as determined by the new health bill. He should undertake certain teaching duties for house physicians, nurses, midwives, health visitors, and so forth, and in this connection he should be closely associated with the local university department of child health.

Appointment

He should be jointly appointed by the appropriate hospital board and local authority concerned, in consultation with the university of the region. It would be an advantage to have some external assessors, such as representatives from another university and the British Paediatric Association.

The emoluments of the post and the conditions of work should be made as attractive as possible in order that ap-

plicants of high standing may be led to apply.

Copies of these suggestions may be had from the secretary of the association at the Hospital for Sick Children, Great Ormond Street, London, W. C. 1.

CONFERENCE CALENDAR

Dec. 9-11—National Commission on Children and Youth, at the Children's Bureau, Washington.

Dec. 9-11—National Society for Crippled Children and Adults, Inc. Chicago.

Dec. 27-28—Society for Research in Child Development. Boston.

Jan. 24-27, 1947—Joint Annual Meeting of the American Statistical Association and the American Economic Association. Atlantic City, N. J.

Feb. 9, 1947—Negro History Week. The theme for the year is "Democracy Possible Only Through Brotherhood." Permanent headquarters: Association for the Study of Negro Life and History, Inc., 1535 Ninth Street NW., Washington 1.

"Before I left the United States, I saw pictures of starving people. Now, God knows, I have seen the reality—it hurts. It is much more gruesome and horrifying than any picture. It is an awful feeling to see people starve before your eyes, and to have nothing in your hands to give them.

"Until you see thousands of refugees milling aimlessly up and down the roads clogged with the homeless, children huddled in broken angles of walls against mothers who offer them no more than a body's warmth, bodies of men bent against wind and sleet and rain, you can't have the faintest conception of what being homeless and hungry actually means. I will be ashamed to be comfortable again. These scenes, repeated over and over with deadly repetition, haunt me. The fight for survival in a foxhole didn't stop—foxholes still are offering shelter to thousands. There is no place in the world for these people to turn to except America."

The Rev. Edward W. Swanstrom, Assistant Executive Director War Relief Services, National Catholic Welfare Conference.

Juvenile Delinquency Conference Meets

What part can the home, the church, and the school take in keeping boys and girls on the right road? What can the police and the juvenile court do to prevent young people from becoming delinquent rather than dealing with them after trouble has arisen? What can recreation services do to help prevent juvenile delinquency? What about better housing?

These are some of the questions that were discussed at the panel sessions of the National Conference on the Prevention and Control of Juvenile Delinquency, which was held at Washington, November 20-22, at the invitation of the Attorney General of the United States.

More than 800 persons attended the conference, which brought together representatives of practically every group in the United States interested in juvenile delinquency.

The members included representatives of private health and welfare agencies, religious groups, youth-serving organizations, organized labor, industry, press, radio, and motion pictures, as well as Federal officials, representatives of State welfare and health departments, State attorneys general, superintendents of institutions for delinquents, juvenile-court judges, and chiefs of police and other municipal officials. More than 90 percent of the delegates represented private agencies.

This was a working conference, not a speech-making one. The only speeches were made at the opening session. After that each participant attended the sessions of 1 of the 16 discussion panels.

The conference was the result of a recommendation by a small group of representatives of agencies concerned with children, which met with the Attorney General in February 1946. This group stressed the need for a conference to which representatives of many fields might contribute.

Some months before the conference met, preliminary panels had been pre-

paring draft reports on the current situation and the needs in each of a number of fields concerned with juvenile delinquency.

These fields, as named in the panel reports, are: Community coordination; juvenile-court law; juvenile-court administration; detention; institutional treatment of delinquent juveniles; role of the police in juvenile delinquency; housing, community development, and juvenile delinquency; recreation for youth; mental health and child-guidance clinics; youth participation; citizen participation; case work-group work services; the church; the school as a preventive agency; home responsibility; rural aspects of juvenile delinquency; and statistics. A panel on press, radio, and motion pictures also met. This panel will not make its report until later; it will report on the role of press, radio, and motion pictures in implementing the recommendations of the other panels.

After the opening meeting of the conference the full panel in each field held three or more sessions to consider the draft report prepared previously. After the panel had discussed and amended the draft, the chairman of that panel presented a summary of the report and recommendations to the full conference at its closing session.

The conference did not vote upon adopting these reports; the chairman of the conference accepted each panel's report and referred it to the executive committee for consideration.

A resolution was adopted creating a continuing committee of 33, which consists of the 8 members of the executive committee, plus the chairmen of the 16 panels, as well as 9 members representing youth.

The continuing committee will stimulate interest and action but the work of implementing the conference at the local level is the responsibility of all the agencies and individuals that took part in the meetings. They must reach out through every medium possible, the conference

resolved, to mothers and fathers, clergymen, teachers, extension workers, and school boards, civic clubs, young people, the press, operators of hotels, motion-picture theaters, bowling alleys, taverns, and other places of commercial amusement, the police, and individual citizens in all walks of life. They must awaken the conscience and mind of every community to action that will assure children and youth the conditions for wholesome life.

Dr. Eliot is President-Elect of A. P. H. A.

Dr. Martha M. Eliot, Associate Chief of the Children's Bureau, is the new president-elect of the American Public Health Association. The election took place at the seventy-fourth annual meeting of the association, which was held at Cleveland, November 12-14, 1946. Dr. Eliot will take office at the close of the next annual meeting, which will be held in Atlantic City, in September 1947, to serve for a year.

Youth employment still above prewar level

In April 1946, Census estimates indicate, about 2¼ million minors, 14 through 17 years of age, were working full time or part time. This was more than twice as many as were working in 1940. Of those working in April 1946, about three-quarters of a million were 14 or 15 years of age (16 percent of the population of these ages).

The estimated total for April 1946 was, of course, much lower than that estimated for April of the previous year, when the war was still going on. At that time, as revised Census estimates indicate, almost 3½ million boys and girls 14 through 17 years of age were at work. Of these about half were then working full time and not attending school; the other half working part time in addition to going to school. The total for April 1945 was 2½ million higher than it was in the spring of 1940, when the decennial census was taken.

In both 1945 and 1946 many thousands of children under 14 years were also at work.

(Continued from page 103)

ANNUAL REPORT OF PLAY SCHOOLS ASSOCIATION, 1945, by Adele S. Mossler, Director. Play Schools Association, 119 West 57th Street, New York 19, N. Y. 24 pp.

If you are one of those whose interest in "bringing the gaps in children's lives created by aimlessly spent and unprotected out-of-school hours" this summary of the activities of 48 play-school centers will encourage you to make permanent plans.

Other workers in this field will find not the least important feature of the report the short section on the pamphlet material prepared by its staff members.

A motion picture showing play schools in action is now in preparation, the report says. Use of this film should be of great value to communities that are trying to bring about awareness of children's need for wholesome creative activities, well supervised, to supplement the effort of their homes.

Marion L. Faegre

THE TREATMENT OF ADOLESCENT GIRLS IN AN INSTITUTION, by Leontine R. Young. Child Welfare League of America, 1945. 37 pp. 50 cents.

Juvenile delinquency is not a mere by-product of the war, says Miss Young, in this report of her experiences at Wallkill Cottage of the Children's Aid Society, New York City, but has existed as long as there were unhappy children; and its roots are multiple, not single.

Wallkill Cottage, with a capacity of 15 girls, cared for a total of 40 girls in its first 3 years, and this evaluation shows that for those not yet too seriously disturbed to be reached by such a program, the cottage or "club" plan was a success. Miss Young found it possible to place dependent, neglected, and delinquent children together when these children were selected on the basis of their individual problems and personality patterns.

No one label could be applied to all the children, as in most cases the delinquent child was really a neglected

child; and the child who was dependent or was officially designated as "neglected" often reacted with delinquent behavior.

Four things the workers considered fundamentally important for successful work with the girls: A genuine liking for the girls themselves, just as they are, with respect for them as persons; an ability to be natural and without pretense; complete honesty with the girls; and a sense of humor—this is basically a sense of perspective and is indispensable. Having only one case worker give her attention to a girl throughout the period helped to achieve the personal relationship that was essential to achieve.

This description of an effort to help disturbed girls in a specialized program and setting should be of value to everyone who is concerned with children and is desirous of planning programs to meet the needs of adolescents.

I. Evelyn Smith

UNEMPLOYMENT COMPENSATION; How it works for working women. Union Series No. 4. U. S. Department of Labor. Women's Bureau, Washington 25, D. C., 1945. 8-page folder.

Addressed to women workers, this folder explains in simple terms how to claim unemployment benefits. It lists the steps in registering for new work and filing insurance claims, and illustrates the steps by simple pictures.

The general provisions, benefits, and coverage of State laws are explained succinctly, and although the reader is reminded of differences in the various States, he is not confused with detailed analyses. Directions are given for obtaining further information.

The material is oriented, naturally, to the needs of the woman worker. For example, States having special provisions restricting the payment of benefits to women under various circumstances are indicated on an outline map of the United States. The information is presented so simply and lucidly, however, that it is of value for boy and girl workers, also.

Hope Castagnola

merely the absence of disease or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, economic or social condition.

The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and States.

The achievement of any State in the promotion and protection of health is of value to all.

Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.

Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

The extension to all peoples of the benefits of medical, psychological, and related knowledge is essential to the fullest attainment of health.

Informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people.

Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

At the end of a perfect Christmas Day, Rossie, on our December cover, is having a quiet "read" before her early bedtime comes. She has already put her dolls to bed, bonnets and all. The photograph is by Philip Bonn for the U. S. Children's Bureau.

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A QUARTER CENTURY OF THE HABIT CLINIC

Reconversion after World War I found the United States with a new and deeper concern for children. It was as if we had grown out of our pioneer and expansionist preoccupations and could now inspect our structure and assess its true values. In the interests of earlier national objectives we had considered children expendable. Now we saw the nonsense of expending our most precious asset. And instead of trying to palliate maladjustment, poverty, disease, and crime, we were demanding understanding and prevention of these disorders. In every field this demand led to the child.

The juvenile court was born in 1899. At that time pediatrics was new; social service for children, as contrasted with child custody, was new; child psychiatry and mental testing were new. In 1909 the child-guidance clinic, combining these four fields of service and applying them to the behavior problems of adolescent children, had been added to the facilities of the juvenile court. Child-guidance clinics grew slowly, and by 1921 were still to be found only in Chicago, Boston, and Baltimore.

It was into this setting that Dr. Douglas A. Thom stepped in 1921 with the novel idea of a psychiatric service for the preschool child. The title "habit clinic" beckoned the parent, the pediatrician, and others who were unready

for the more complex idea of a psychiatric clinic for little children. That Grace Abbott, then Chief of the United States Children's Bureau, helped to develop this service is characteristic of her vision.

The habit clinic's principle of dealing with difficulties in a child's environment before they get inside the child himself was solid ground, upon which psychotherapy was later built. As psychotherapy became more prevalent, environmental manipulation lost caste, but it has recently regained respectability as the treatment of choice for children for whom psychotherapy is contraindicated, unnecessary, or impossible.

It was significant that in 1921 a child-health center should have asked Dr. Thom to study its psychiatric needs and have followed his recommendation to establish the habit clinic. Dr. Thom's organization was simple—a man, a pencil, a pad, a chair and table, and a child.

Many pediatricians undertook to incorporate Thom's purposes and methods into their own private and out-patient clinic practice. Some, such as Aldrich, took on this comprehensive pediatrics seriously. Others were ready for a new tool but not a new concept and hardly did justice to Thom's leadership.

The habit clinic appeared on the scene at a time when groups of parents were in need of formulations that were

within their grasp. And Thom's book, "Everyday Problems of the Everyday Child," his habit-training leaflets, and his Children's Bureau pamphlets, "Habit Clinics for the Child of Preschool Age" and "Child Management," all growing out of the experiences of the habit clinic, helped to bring about better understanding of children by parents and teachers and to turn clinical attention to the behavior problems of the young child. Some of these early publications have passed on, but the newer publications that replace them have been built upon these foundations.

The habit clinic led directly to the first State program of preventive mental hygiene, under Dr. Thom, in Massachusetts. But Thom was always cautious about claiming a preventive value for the habit clinic. He felt that the immediate values to the child provided sufficient justification for this work. But in addition the habit clinics have contributed to and helped organize our knowledge about child behavior and have provided a vehicle to transmit this knowledge to the medical profession and the lay public.

The twenty-fifth anniversary of the establishment of the habit clinic marks a quarter century of outstanding service to children.



GEO. S. STEVENSON, *Medical Director
The National Committee for Mental Hygiene*

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CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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JANUARY 1947

THE CHILD



Action Program for 1947 and 1948

To conserve the gains that have been made and to go forward toward the achievement of its purposes in behalf of all the children and youth, the National Commission on Children and Youth has adopted the following *action* program for 1947 and 1948:

1. EXTENSION OF SOCIAL-SECURITY PROGRAMS AFFECTING FAMILY INCOME

—To seek increased coverage and benefits under social insurance, public-assistance programs, and other benefits.

2. EXPANSION OF FEDERAL AND STATE COOPERATIVE PROGRAMS FOR CHILD WELFARE

—To press for Federal and State legislation that makes possible achievement of a comprehensive program of child-welfare services, within broad programs of public welfare, available in every State.

—To work for better protection of the rights and welfare of children and youth through State legislation, such as laws relating to adoption, guardianship, illegitimacy, juvenile delinquency, and other aspects of child welfare.

3. EXPANSION OF FEDERAL AND STATE COOPERATIVE PROGRAM FOR MATERNAL AND CHILD HEALTH

—To press for Federal and State legislation that makes possible the achievement of complete health and medical-care services for all mothers and children in every State, including services for crippled children.

—To press for Federal and State legislation that will make possible the development of health services for school children through joint action by school and health authorities.

4. EXPANSION OF MENTAL-HEALTH AND GUIDANCE PROGRAMS FOR CHILDREN

—To work for the inclusion in health education and welfare programs of mental-health and guidance services for children and youth at all stages of their development.

5. FEDERAL AND STATE AID TO EDUCATION

—To press for Federal and State financial aid to public education that will make fully available educational opportunity for all children from nursery school through high school, adapted to individual capacities and the special needs of each child.

—To insure for all youth, regardless of their economic status, full access to advanced liberal, technical, and professional education, in accordance with their interest and capacities.

—To extend and improve all school services essential to the development of a rounded school program.

6. RECREATIONAL OPPORTUNITY

—To work for the development of recreational services and facilities as a public responsibility, with Federal and State advisory services on community recreation programs.

—To encourage planning for recreation by public and voluntary agencies directed toward services to all children and youth, and particularly to areas which have not yet developed such services.

7. IMPROVED CHILD-LABOR LEGISLATION

—To press for extension of the child-labor provisions of the Fair Labor Standards Act to cover all employment in or in connection with interstate commerce, including industrialized agriculture.

—To raise standards of State legislation to set: A 16-year minimum age for any employment during school hours and for work at any time in manufacturing and mechanical establishments; a 14-year minimum for other employment outside of school hours; a maximum of 40 hours a week and no night work.

—To extend compulsory school-attendance laws to cover all children between 6 and 18 years of age, with allowance for legal employment of those 16 and 17 years of age and exemption of high-school graduates.

8. EMPLOYMENT OPPORTUNITIES

—To work for expansion of public employment facilities for counseling and placement of young people, to be developed in close relationship with schools and other community agencies.

—To urge the inclusion of work opportunities for youth in public planning for full employment.

9. STATE AND COMMUNITY PLANNING FOR CHILDREN AND YOUTH

—To extend and strengthen State and community committees planning for children and youth on a continuing basis.

—To obtain advisory service and assistance for such committees from the Children's Bureau and other Federal agencies.

10. YOUTH PARTICIPATION

—To encourage the cooperation of youth groups in the planning and development of community services on which they can make a contribution.

11. INTERNATIONAL PROGRAMS

—To encourage, through the United Nations and other appropriate organizations, international action that will strengthen services for children and youth.

Newly formed National Commission on Children and Youth calls for major advances in '46 and '47

CORNELIA GOODHUE,

Division of Reports

THE NATIONAL COMMISSION on Children and Youth, successor to the National Commission on Children in Wartime, held its first meeting in Washington, December 9, 10, and 11. The 60 members of the commission had invited representatives of State commissions and councils for children and youth, members of the Children's Bureau staff, and other Government advisers to meet with them.

The commission members felt that they were in such general agreement on goals that standard-setting resolutions were unnecessary at this time and decided to devote the conference primarily to questions of method.

The chairman, Leonard W. Mayo, president of the Child Welfare League of America, explained the role of the commission in working for the benefit of children and youth and presented a tentative draft of a program of action based on proposals made by the former commission. He expressed the attitude of the commission when he said, "We know what should be done. We must now find out, *in detail*, why these things don't get done."

Four speakers outlined in clear, forcible terms the difficulties standing in the way of action.

Dr. Henry F. Helmholtz of the Mayo Clinic, speaking for the health services, analyzed the urgent needs as: Better support and cooperation from the medical profession; better distribution of the available medical personnel and some means of attracting more students to the medical, nursing, and allied professions; and development of organized health services in all our 3,000 com-

munities. He commented on the value of the information that will come from the study of child-health services now being made by the American Academy of Pediatrics with the help of Federal and State agencies.

Dr. Ellen Winston, commissioner of public welfare in North Carolina, spoke for the social-service programs, listing the problems as involving admin-

istration, legislation, finance, and personnel. She asked for clearer definition of child-welfare services and their relation to the total welfare program and stressed the need for preventive, rather than merely remedial, services.



“ . . . Complete health and medical-care services for all mothers and children in every State . . . ”

istration, legislation, finance, and personnel. She asked for clearer definition of child-welfare services and their relation to the total welfare program and stressed the need for preventive, rather than merely remedial, services.

Dr. Willard E. Givens, executive secretary of the National Education Association, described conditions in the public schools today and asked the commission to consider several questions: Is education an investment or an expense? Should we have Federal sup-

port for public education or for all education? How is “equalization of educational opportunity” to be accomplished? And, lastly, are we going to educate our Negroes or are we not?

Mrs. Gertrude Folks Zimand, general secretary of the National Child Labor Committee warned against the false issues, or smoke screens, frequently raised in discussions of child labor and

asked the commission to confine itself to real issues which she listed as: Whether the 16-year minimum age is too high? Whether compromise agreement should be accepted in some cases? And whether agriculture should be regulated on the same basis as other types of labor?

After this general presentation of the problems the members and the representatives of State commissions met in four groups to discuss ways of achieving progress in solving them. Clyde E.



" . . . Public employment facilities for counseling and placement of young people . . . "

Murray, president of the National Federation of Settlements, Mary E. Loeper, executive secretary of the Association for Childhood Education, Dr. George S. Stevenson, medical director of the National Committee for Mental Hygiene, and Miriam R. Ephraim, associate director of the National Jewish Welfare Board, were appointed leaders. One morning and two afternoon sessions were given over to these discussions. The recommendations of the separate groups were later combined by a special committee and presented to the conference as a whole. The group discussions also brought out many valuable suggestions for action and concrete descriptions of action programs which had been successful in various localities. A committee is now studying this material and will make a detailed report as soon as possible.

Further suggestions for action were made at an evening meeting at which Federal officials spoke on the question: How can citizens work with the Eightieth Congress in behalf of children and youth?

On the last day the conference again met as a whole and heard the reports and recommendations of its special committees and discussion groups.

The committee on the relation of the commission to Federal agencies, through its chairman, Leonard W. Mayo, recommended that the commission appoint certain subcommittees to

work with special Federal agencies and that it authorize the Chief of the Children's Bureau and certain members of the commission to confer with representatives of the Attorney General's Conference for the Prevention and Control of Juvenile Delinquency on plans for the follow-up of the conference.

John W. Andrews of the Department of Justice commented briefly on the Attorney General's Conference for the Prevention and Control of Juvenile Delinquency. Mr. Andrews explained that the continuing committee set up by the conference was not to be looked upon as a new organization but rather as a clearinghouse of information and resources which would work in consultation with the constituent organizations in whatever ways they found useful.

For children the world over

The committee on international programs for children, with Mrs. Harriet Ahlers Houdlette, American Association of University Women, as chairman, offered seven resolutions, touching on various phases of the United Nations work affecting children; programs now being developed in the American Republics; problems of the Philippines and other Pacific areas; and urging aid to distressed children the world over. This committee had held an open meeting the first evening of the conference and commission members felt that the

facts called for even stronger language than had been used in the resolutions. They were presented to the commission later, with revisions, and were unanimously accepted. At the same time a resolution was passed commending the President of the United States for his directive making it possible for unaccompanied and displaced children in certain zones to come to the United States and asking the Children's Bureau to explore means of increasing the number of children eligible to come to this country.

Representatives of 17 State commissions and councils for children and youth who were present as guests of the commission met separately to discuss the organization and problems of local commissions. Their chairman, Walter M. Berry, executive secretary of the Michigan Youth Guidance Commission, reported to the meeting briefly and offered three recommendations to the National Commission, which were accepted. These were: That the Children's Bureau prepare a statement on principles and methods for the use of State commissions and similar planning groups; that the Attorney General's office be asked to send the report of the Conference for the Prevention and Control of Juvenile Delinquency to these commissions and councils; and that they be called upon to assist in plans for a 1950 White House Conference.

The combined recommendations of the discussion groups were presented and, after some modification, accepted by the commission as a whole. Other recommendations offered from the floor were added at this time.

The chairman of the committee on principles and policies, Boris Shishkin, American Federation of Labor, then presented an 11-point action program, which was considered, revised, and adopted. This program is given in full on page 114.

Other recommendations growing out of the group discussions related to procedures to be followed in seeking the action advocated. Subject to revision by the editorial committee these recommendations are as follows:

A. Special emphasis in the program of action.

1. That the National Commission, through its executive committee, relate

itself in whatever form is feasible to the newly appointed President's Committee on Civil Rights; that it urge the appropriate Federal and State agencies to take the necessary steps—legislative, administrative, and financial—to raise the level of services for all children to the levels which are now available for some children; and that in the development of programs it spell out in specific terms what is meant by equal opportunity for all children; and that it study the problems of children, within or outside family groups, who are migrant or transient.

B. Personnel

2. That the National Commission call for a study, by an appropriate body of the personnel requirements of the professional service occupations in the United States; of the training facilities required for such personnel; of the salaries which must be paid to attract and adequately remunerate the workers; and of the public funds needed to implement an adequate program. The study should summarize the immediate and long-term programs for education, welfare, medical service, scientific work of a public nature, and other requirements for which trained personnel is required. It should determine what proportions of the national labor force are needed in these occupations, what the present deficiencies are, and how they may be remedied. It should review vocational guidance, training and education, facilities for placement, salary and other inducements. Finally, it should suggest a program of action, with an estimate of costs. With such a study the problem could be approached on the basis of national need, rather than as unrelated deficiencies of manpower.

3. That the commission call to the attention of the appropriate organizations and agencies the need for developing trained leadership capable of promoting youth participation in activities and planning that will result in active, responsible citizenship.

4. That the commission call together leaders in the universities, training centers, and professional organizations involved in services to children to discuss problems arising from the interrelatedness of different fields.

C. Information and materials

5. That the Children's Bureau and other Federal bureaus and national agencies be asked to prepare material on youth councils, parent-education programs, and leadership-training courses and institutes, showing what is being done along these lines and the methods used.

6. That descriptions and evaluations of specific experiments of interest to

within the Children's Bureau an advisory service qualified to assist State and local planning groups in the children's field with information on organization, financing, and general aspects of this work.

11. That the National Commission, recognizing the value of the present programs of research and consultation in the field of State legislation bearing on the welfare of children and youth



“ . . . Educational opportunity for all children from nursery school through high school . . . ”

commission members, including descriptions of methods employed in overcoming barriers to action on the local level, be written up and made available from time to time.

7. That the National Commission take steps to secure a more adequate exchange of information on State legislation, programs, and projects.

8. That the executive committee of the commission appoint a subcommittee to consider the possibility of getting professional help for developing radio scripts and audio-visual and other materials for interpretation of programs, services, and legislation, and that State commissions be drawn upon for their experiences in this area.

9. That all materials on youth and youth needs be put in language that is easily understood.

D. Advisory services

10. That the executive committee consider the possibility of developing

and the growing need for such services, recommend that steps be taken by the Children's Bureau and other Federal agencies to extend these services in order to meet the requests originating in the several States.

12. In view of the fact that many State legislatures will be meeting next year and the Eightieth Congress will be in session, attention should be given to proposed State and Federal legislation, and State commissions and other organizations should be encouraged to assume responsibility for interpretation of bills presented and to support those measures which in principle embody the proposals of the National Commission on Children and Youth.

E. State commissions

13. That appropriate State bodies consider the possibility of calling a State conference or meeting to study and discuss the data compiled at this and other recent national conferences on children and youth.

14. That the National Commission take steps to further the proposals of the National Commission on Children in wartime for extending State-wide planning for children and youth through State councils, commissions, planning boards, and so forth.

15. That financial support be provided for effective cooperation with State committees and commissions.

16. That the States be encouraged to organize commissions on children and youth, on which youth and all population elements are represented, to study and report on local needs.

F. National Commission organization

17. That the National Commission consider the desirability of inviting to future meetings representatives of State commissions on children and youth and other State agencies and departments, and public and private agencies in the Territories, the specific agencies to be included being determined in the light of the agenda for those meetings.

18. That the National Commission encourage national organizations to develop within their organization plans for promoting legislation and means for coordinating these plans with those of other organizations.

19. That the executive committee appoint a subcommittee to study the recommendations growing out of the Attorney General's Conference for the Prevention and Control of Juvenile Delinquency and consult with the continuing committee of that conference.

G. 1950 White House Conference

20. That the National Commission strongly support the calling of a 1950 White House Conference on Children and Youth.

21. That the conference be supported, as far as possible, by public funds and that a special appropriation be made for this purpose.

22. That the membership of the conference be broadly inclusive and represent all sections of the population.

23. That the program should stem from local communities rather than feed from the conference to local communities.

24. That programs of popular education to stimulate State and local interest be conducted throughout the country in advance of the conference so that its

findings may have greater acceptance.

25. That the conference should dramatize the needs of children for the general public in order to stimulate programs for children.

26. That one of the major aims of the conference should be to prepare the children and youth of our Nation for their part in building a peaceful world.

27. That the conference plan, as far as possible, a program of work for the following decade and determine priorities in the selection of jobs to be done, in terms of money, personnel, and time.

28. That the National Commission on

cies associated with the Economic and Social Council and its hope that the Social Commission will establish promptly a subcommission for work in the child-welfare field; (d) Urges the members of the Commission to study, and make better known the programs affecting children developed under the auspices of the United Nations and the specialized agencies, such as UNESCO, ILO, WHO, and FAO; (e) draws attention to the importance of providing a basis for cooperative activities between the governments of the Philippines and the United States in developing pro-



“ . . . Development of recreational services and facilities as a public responsibility. . . . ”

Children and Youth be closely identified with the planning of the conference.

H. International programs for children (Condensed)

In view of the urgent and distressing need of children from all countries suffering from the effects of war, and the importance of making effective help available as rapidly as possible in order to save the children of the world and enable them to live and grow in health and security, the National Commission and Youth—(a) Urges the mobilization of all possible resources in behalf of children wherever they may be found; (b) Commends the establishment of the International Emergency Children's Fund of the United Nations; (c) Expresses approval of the emphasis given to child welfare in the resolution establishing the Social Commission and in the programs of the specialized agen-

grams for the health, education, and welfare of children and young people, including the exchange of experts and the training of personnel. (f) Commends the cooperation between the American Republics in the development of programs and the training of personnel in the fields of child health, welfare, and education, and urges the extension of such programs to other countries; (g) Recommends that plans be developed for the health, education, and welfare agencies responsible for their administration, working in cooperation with the Children's Bureau, the Office of Education, and other appropriate agencies. Expresses the hope that organizations will continue and increase their own programs of participation in aid to the distressed children and families of the world.

Reprints available on request

HOW MARY AND JIMMY GROW

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Children are not like peas in a pod. And we must use discretion when we compare Jimmy and Mary with each other.

FOR MANY YEARS knowledge of the development of children and of the role of the two interacting forces, heredity and environment, has been accumulating. Today there is a large body of knowledge that can be utilized in understanding children and in providing them with an environment which gives them freedom to grow. This knowledge is effective insofar as it is applied to individual children. What does it mean, for example, to Mary and Jimmy and their families?

Both Mary and Jimmy have definite potentialities for growth, which have been given to them by their parents. These potentialities, unique for each, determine the limits beyond which they cannot grow. Whether or not they attain their full growth is dependent upon their environment. The Jimmys and Marys are not born equal. No two persons, with the exception of identical twins, have equal endowment. Two children, even in the same family, may come into the world endowed with bodies that may respond differently to the same environment. A child may have strengths and weaknesses which make him more resistant in some areas and more vulnerable in others. In order to help Mary and Jimmy attain their optimal growth it is necessary to understand them as persons—their strengths and weaknesses—and thus have a realistic basis for expectations of them. Parents must know their children so that they may plan intelligently for them.

Because children are not like peas in a pod, comparing Jimmy and Mary with each other and with other children

must be done with discretion. Since Jimmy is a boy and Mary a girl they cannot be expected to have similar growth patterns. Boys, for most of their growing years, are generally taller and heavier than girls; girls generally mature earlier than boys. The difference in physical maturation, as measured by skeletal development, is noticed early in infancy and increases in magnitude with age. In infancy the difference is a matter of months; in the early elementary years it is about a year, and in the high-school years it increases to about 2 years. Girls also mature sexually earlier than boys. Since the pubescent spurt of growth is associated with sexual maturation, girls have this spurt of growth before boys. This spurt comes at about 12 to 14 years of age. Therefore, for the relatively brief period of about 2 years girls are taller and heavier than boys.

Patterns of growth differ

Jimmy's and Mary's patterns of growth may be quite different from those of their friends. A child may be an early maturer, a late maturer, or somewhere between the two extremes. Likewise there are slow, fast, and just average growers. Early maturing chil-

dren compared with late maturing children begin their pubescent spurt of growth at an earlier age, are larger when this spurt begins, grow faster, and are generally shorter at maturity. On the other hand, the late maturers begin at a later age, have a slower rate of growth for a longer period of time, but generally arrive at maturity taller than the fast maturers. Early maturers during pubescence, therefore, are large for their age, both taller and heavier than late maturers. Shuttleworth¹ found that at an age when differences in height and weight were greatest, girls with a menarche before 12 years, 6 months, were from 1.6 percent to 15.6 percent taller and 33.6 percent heavier than girls with a menarche after 13 years, 5 months. If such children's weight were evaluated by height-weight standards, without consideration of their maturational status, the late maturers would be classified as underweight and the early maturers as overweight. Attempts to change these so-called overweights or underweights would probably result

¹ Shuttleworth, F. K.: *The Physical and Mental Growth of Girls and Boys Age Six to Nineteen in Relation to Age at Maximum Growth*. Monographs of the Society for Research in Child Development, vol. 4, serial No. 22, No. 3, 1939.

only in frustrations to parents and children.

Children may also differ in physique. There are stocky children; there are slender children; there are all gradations from stocky to slender. Again the evaluation of weight may be entirely wrong if physique is ignored. The stocky child may be classed as overweight; the slender child may be classed as underweight. According to the Pryor tables² two 6-year-old boys who are 46 inches tall but of different breadth may vary by 11 pounds in weight.

As has been indicated before, children of the same chronological age may be quite different in their stage of maturity. For example a group of 14-year-old boys³ were observed to vary in skeletal age from 12 years and 4 months to 15 years and 8 months. These boys also varied in size and in the development of primary and secondary sex characteristics. Such great differences will be reflected in the boy's interests. Adults need to recognize these differences when planning programs or setting expectations for these boys. It is readily seen that classification of groups according to chronological age alone whether in school or recreational groups is fraught with much difficulty.

Needs are individual

Because of these differences in size and the development of children, their needs, while qualitatively similar, may vary quantitatively. Two 3-year-olds who differ by $5\frac{1}{4}$ inches and $17\frac{1}{2}$ pounds will not require the same amount of food. The fast-growing child has a greater demand for food to meet his needs for growth than does the slow grower. Likewise the very active child will need a greater supply of energy than the quiet child. During pubescence fast growers need to be watched to see that they have adequate food and sleep. Sometimes the pressures of the social group at this age make it impossible for young people to maintain good habits of sleeping and eating. It is evident, therefore, that the practices in feeding children must be reviewed in terms of the growth patterns of individual children.

Jimmy and his sister not only have bodies, but with these bodies they feel and think. In providing for their physical needs, therefore, these other aspects

of their life cannot be neglected. In evaluating the food habits of a child at any time, nutritionists must reckon with the children's feelings. Anxiety or worry interferes with appetite and the digestion of food. A child can have anxieties at any age, though sometimes these anxieties are not apparent at first glance. On the other hand children who are insecure or who are deprived of the satisfaction of being loved may resort to overeating to compensate for the lack of satisfaction of these emotional needs.⁴

Many forces interact

Adults who are concerned with the physical aspects of a child's life may fail to see the importance of the psychological aspects. In turn, persons concerned primarily with the emotional and intellectual needs of the child may neglect to watch for physical factors that may be affecting behavior. A child poorly nourished because of stomach hunger or hidden hunger has not the energy to work or play to the limit of his ability. A child with an uncontrolled allergy may be irritable and show erratic behavior. A tired child may be cross and hyperactive, or he may be apathetic. A food aversion may be traced to a former illness, when lack of appetite and parental concern operated together to create a dislike for certain foods. Thus it is important to look at each child as a unit in which many forces are interactive.

Jimmy and Mary live in a family, which is an environment consisting of material things and persons. Before becoming a member of this group they have their first environment within their mother's body. The idea that a fetus is merely a parasite needs to be modified. Studies by Burke⁵ and Ebbs and Tisdall⁶ indicate that the baby as well as the mother may suffer if her diet is not adequate. In the Burke study mothers with excellent or good diets had a higher percentage of superior babies. Ebbs and Tisdall found enough differences in the babies of mothers with a good diet and those with a poor diet that these babies at 6 months of age could be recognized as belonging to one group or the other.

There are also some indications pointing to the fact that congenital malformations may be due to a poor maternal

² Pryor, H. B.: *Width-Weight Tables*, Second revised edition. Stanford University Press, 1940.

³ Greulich, W. W., R. I. Dorfman, H. R. Catchpole, C. I. Solomon, C. S. Culotta: *Somatic and Endocrine Studies of Puberal and Adolescent Boys*. Monographs of the Society for Research in Child Development vol. 7, serial No. 33, No. 3, 1942.

⁴ Bruch, H.: *Obesity in Childhood*. III, Physiology and Psychologic Aspects of the Food Intake of Obese Children. *American Journal of Diseases of Children* 59: 739-751, 1940.

⁵ Burke, B. S., V. A. Beal, S. B. Kirkwood, H. C. Stuart: *The Influence of Nutrition During Pregnancy Upon the Condition of the Infant at Birth*. *Journal of Nutrition* 26: 569-583, 1943.

⁶ Ebbs, J. H., F. F. Tisdall, W. A. Scott: *The Influence of Prenatal Diet on the Mother and Child*. *Journal of Nutrition* 22: 515-526, 1941.

(Continued on page 125)

Mothers learn from the nutritionist that children of the same age may require different quantities of food.



BRITISH MEDICAL GROUPS

STUDY PSYCHIATRIC SERVICES

THREE British medical associations—the Royal College of Physicians, the British Medical Association's group of practitioners of psychological medicine, and the Royal Medico - Psychological Association—have made joint recommendations regarding the organization of psychiatric services in a national health service. Some of these recommendations, applying to children, are as follows:

Scope of psychiatry

2. The mental-health department of the health service of the future should be responsible for the organization of all medical work which is essentially psychiatric.

3. The psychiatrist is not concerned only with fully developed mental disorders. The mental-health service should include provision for prophylaxis of mental disorder over the widest field.

4. In the educational sphere psychiatric advice is essential for children showing neurosis, behavior disorder, or mental defect.

Administration and staffing

10. There should be formed a mental-health authority with appropriate statutory powers in each area throughout the country as may be decided hereafter by the Government, such authority to be responsible for all aspects of mental health; * * * Close cooperation should be maintained between these authorities and the public-health and education committees and those responsible for the voluntary hospitals.

11. On any local advisory bodies, such as the local health-services council, there should be adequate psychiatric representation.

15. A special medical officer should be appointed in each area as adviser and executive officer to the mental-health authority of whatever body coordinates all branches of mental health. He should be an officer of senior status with

clinical and administrative psychiatric experience.

22. There should be a coordinated system of psychiatric social service. All psychiatric social workers should receive such training as will fit them for service in all branches of the specialty.

26. The status of mental nursing should be equal to that of general nursing. All general nurses should receive some training in psychiatric nursing.

Psychoses and psychoneuroses

33. While it is desirable that the great majority of psychoneurotics should not be treated in mental hospitals, a certain number may be admitted, dependent on the degree of disorder and abnormality of behavior and the sensitiveness of the patients to their surroundings, * * * this would entail that the mental hospitals should be so reorganized as to provide suitable facilities for in-patient treatment for all types and degrees of mental ill health, including neuroses, by the provision of suitable separate units * * * to guarantee adequate grading.

Mental subnormality, including mental deficiency

35. It should be recognized that mental subnormality and its social consequences undoubtedly provide a very wide problem.

36. The present legal and administrative procedures need revision:

(c) To enable any subnormal child to receive without strict formality or legal certification such special education as may be necessary (now likely to be provided under the Education Act).

(d) To provide for the whole group of the subnormal rather than for the restricted portion who are certifiably defective.

38. The entire service of the subnormal should be transferred from the

public-assistance authorities to the mental-health authority.

39. For the retarded group an increased number of special schools, both residential and day, is required. More occupation centers should be established.

40. Mental - deficiency institutions should be on the colony plan. Each should accommodate a cross section of the mentally defective population and none should be reserved for low-grade defectives.

41. The community care of the retarded class and license from institutions should be widely extended. All large institutions should have several branches, both for use as hostels and for training.

45. It is desirable that a psychiatrist should be appointed to every education authority, and in all cases there should be close cooperation between general practitioners and medical officers and psychiatrists working in the field of mental deficiency so that consultations may take place, whenever necessary, in regard to educability of particular children and the ascertainment of defect.

Child psychiatry

46. Since prevention is the most important part of the work of the future health service a child-psychiatry service must be an integral part of any adequate mental-health services. Child-guidance clinics, with associated in-patient facilities, are required in every area, and should be under the management of the mental-health committee, working in close cooperation with education authorities.

47. As an important prophylactic measure there should be systematic psychological examinations of every school child. These examinations should be primarily the function of the educational psychologist, but all cases showing emotional instability or serious intellectual subnormality should be referred for full psychiatric examination.

48. Residential school treatment under psychiatric direction should be made available for maladjusted children, preferably by voluntary admission.

SOURCE: Memorandum on the Future Organization of the Psychiatric Services. Royal College of Physicians, London, 1945.

CLOTHING FOR CHILDREN

CLOTHING and other materials are needed by the American Friends Service Committee in its work to relieve suffering at home and abroad, where its representatives are continuously active. Their work is made possible by contributions from Americans of good will.

Shipments are made to:

1. United States: A center in the bituminous coal fields; centers in the south; migrant workers; sharecroppers; others as needs arise. (The needs are those familiar to American communities.)
2. Europe: Austria, Finland, France, Germany, Holland, Hungary, Italy, Jugoslavia, Poland.
3. Asia: China and Japan.

Articles of clothing for Europeans

Babies—Baby clothes, new or old, are suitable. All manufactured styles are acceptable. If new yard goods are to be made up, the committee suggests any of the following layette items:

European layettes—(May be contributed by the complete layette or by the piece.) Mothers are happier when they can dress their babies in the way they would if they could provide for them themselves. Only the shirts are different. The European mother likes a style similar to the American sacque. It will add greatly to the mother's joy. European houses are never heated as much as American homes. Scarcity of fuel now calls especially for warm baby clothes.

6 binders—thin cotton or wool flannel. 2" x 28". Sew a 7" tape at each end.

12 diapers—36" square. Made of lightweight unbleached muslin, double cheesecloth, or birds-eye. May also be regular oblong American type.

6 diapers—36" square. Made of cotton flannel.

6 shirts—3 large, 3 small. Make according to baby sacque pattern. Material may be nainsook, soft muslin, linen (old linen may be used if it is strong).

3 jackets—wool flannel. Use baby sacque pattern. Neck and sleeves may be feather-stitched, bound with ribbon, or finished with lace if desired.

2 cotton blankets.

1 or 2 wool sweaters.

2 wool blankets or afghans, at least 36" square.

1 cap—knit or wool flannel.
3 bibs.

Older babies (age 1 to 3)—Outdoor wear, undershirts, bloomers, woolen soakers, bedroom slippers, rompers, dresses, panties, overalls, sweaters, night clothes, slips, stockings, shoes.

Girls—Outdoor wear, dresses, underwear, night clothes, knee-high socks, skirts, sweaters, aprons.

Boys—Outdoor wear, trousers (not knickers), shirts, sweaters, knee-high socks, underwear, night clothes, short pants.

Women—Coats, sweaters, dresses, underwear, stockings, night clothes, smocks, aprons. Many older women in Europe wear black, as mourning is always worn for close relatives. Black dresses of any material are very much needed. One of the greatest needs is for sanitary napkins, which may be made of old sheets, linen, or new materials such as flannel, birds-eye, double cheesecloth, muslin. Any size.

Men—Coats, sweaters, suits, trousers, underwear, socks, night clothes, shirts (if no collar attached, pin one to shirt).

Knit garments—Woolen garments are always needed. Any good styles are acceptable. The A. F. S. C. purchases knitting worsted and resells at cost to those who knit for the committee's work. Write AFSC, 23d and Arch Streets, Philadelphia 3, Pa.

Shoes—New or second-hand (cleaned and repaired). An extra pair of laces in each pair of shoes will help. (Shoe laces are very scarce in Europe.)

Special needs

Soap—Needed everywhere. Bath and laundry soap (cakes only); homemade soap.

Bedding—Towels, washcloths. Quilts, blankets, sheets, pillowcases (new or used).

Sewing materials—Most practical is a drawstring sewing kit containing black and white thread, darning cotton, needles, pins, assorted buttons, scissors, elastic, etc.

Preparation of garments

Repairing—New clothing is always acceptable, but not always obtainable.

One of the most useful services that can be rendered is thorough repairing of good second-hand clothing. This includes the small jobs like sewing on snaps or buttons or the larger tasks like patching or relining. But don't waste time repairing a threadbare garment.

Cleaning—All soiled articles should be dry-cleaned or washed. The spirit of the recipient is helped by receiving a clean article. Soiled or torn articles will not be shipped. Pressing is not necessary.

Remaking—Some garments too worn to be useful in their present forms can be remade into useful articles. Worn blankets can be cut down to smaller sizes or used as linings for quilts. Write to the American Friends Service Committee for leaflet, "New Garments From Old."

Shipping

Ship prepaid—parcel post, express, freight—to one of the addresses at the end of this article.

Wrap securely. Address legibly. Give your name and address so that the A. F. S. C. can let you know your gift has been received.

Things not needed

Straw hats, shoes needing repair, high-heeled shoes, men's collars (except when pinned to shirt of same size), trinkets, belts, old stockings; anything too worn for continued hard service.

Gifts should be sent to one of the following A. F. S. C. packing centers:

23rd and Arch Sts., Philadelphia 3, Pa.
501 N. Raymond Ave., Pasadena 3, Calif.
District of Columbia only, 2111 Florida Ave. NW., Washington 8, D. C.
159 N. Michigan Blvd., Chicago 1, Ill.
2151 Vine St., Berkeley 7, Calif.
New York and vicinity only, 144 East 20th St., New York 3, N. Y.
1212 King St., Seattle 44, Wash.
Boston and vicinity only, 5 Longfellow Park, Cambridge 38, Mass.
Baltimore only, 3107 N. Charles St., Baltimore 18, Md.

For Finland: 18 Warren St., New York 4, N. Y.

For Japan: Pasadena or Seattle address (above).

Make all checks and money orders payable to: American Friends Service Committee. Please do not send cash through the mail.

American Friends Service Committee, 20 South 12th St., Philadelphia 7, Pa.

Thirteenth National Conference on Labor Legislation

"We are now at one of those critical times in our economic life when everyone expects a turning point of some kind," said Secretary of Labor Schwellenbach in his welcoming address at the Thirteenth National Conference on Labor Legislation, held in Washington, December 2 to 4, 1946. In regard to child labor Mr. Schwellenbach pointed out that the large number of young people still employed has kept both State and Federal enforcement problems boiling.

Among the resolutions adopted by the conference was one on child labor, which referred to the young people of the Nation as "its most valuable resource for building the stable economic and social future that alone will enable us to contribute to the fullest extent possible to the peace and security of the world" and reiterated the position of the conference in urging active promotion and support by State labor officials and representatives of organized labor and all other interested organizations, of the following objectives: For State legislation, a basic 16-year minimum age for employment, and for minors under 18, limitation of hours of labor, prohibition of night work, and protection from hazardous occupations; for Federal legislation, extension of child-labor coverage to all establishments engaged in interstate commerce.

Another resolution urged that every effort be made to assist the International Labor Organization in carrying out its aims and purposes. A report on international labor affairs was given by Davis A. Morse, Assistant Secretary of Labor.

Among the reports presented by committees was one on migratory labor which recommended, among other legislative measures, the extension of State child-labor laws and the child-labor provisions of the Fair Labor Standards Act to cover children employed in agriculture, both during and outside of school hours.

The report points out that because the migratory worker and his family mov-

ing from place to place are dependent on the resources of the community to which they go for health, welfare, child care, education, recreation, and other community services, full cooperation between State and local agencies concerned and citizen groups is important for the development and maintenance of such services.

The conference was attended mainly by State labor commissioners and representatives of organized labor. The Governors of 43 States sent representatives, as did the District of Columbia and Alaska. (A few representatives of national organizations and individuals were invited because of their special knowledge of State labor legislation.)

A résumé of the proceedings of the conference has been printed as Bulletin No. 85 of the Division of Labor Standards, U. S. Department of Labor (42 pp.).

For Welfare of Chinese Children

Chinese child-welfare workers held their first nation-wide conference, in Shanghai, November 4 to 9, 1946, with approximately 140 delegates attending from north, west, south, east, and central China. Held under the auspices of United Service to China, the conference brought together child-welfare workers who had not seen each other since before the start of the Sino-Japanese War in 1937. In 1944 United Service to China, formerly United China Relief, called a child-welfare conference, but at that time of course those workers in Japanese-occupied China could not attend.

In addition to the Chinese, there were western child-welfare specialists now in China for UNRRA and loaned to CNRRA. Two Children's Bureau workers took a leading part in guiding the conference, Vinita Lewis and Bernice Scroggie. UNRRA and CNRRA arranged for all their workers in the field of child welfare to come to the conference, where they acted as consultants in the several small groups into which

the larger assembly divided for detailed discussion and recommendations.

Dr. W. Carson Ryan of the University of North Carolina, Dr. Ernest G. Osborne of Teachers College, Columbia University, and Vinita Lewis took major responsibility in guiding the conference. Mrs. Nora Hsing Chu, the leading Chinese child-welfare specialist, was the conference executive.

The report of the conference will be made in English and in Chinese. Entitled "Child Welfare in China," it will be about 64 pages long and will include the following sections: 1. The Child Welfare Planning Conference of 1946. 2. Health of Children. 3. Institutional Care. 4. Education of Children. 5. Youth Problems. 6. Education of Parents. 7. Professional Training of Child-Welfare Workers. 8. Public and Private Child-Welfare Agencies. 9. A Child-Welfare Program. 10. Officers and Members of the Conference.

The report will be used in university training classes and should be most useful in view of the scarcity of textbooks on material relevant to Chinese child-welfare problems.

Out of the conference grew a demand for an office of professional child-welfare services in China. It was decided to call the new organization China Child Welfare Service. It will in time become the organization of professional child-welfare workers but is now sponsored and supervised by United Services to China.

Mildred Price
Executive Secretary, China Aid Council, Inc.

Illinois Children's Hospital-School Opens

The Illinois Children's Hospital-School, first State institution of its kind in the country, was opened in Chicago on September 24.

The institution, which was set up for educable handicapped children, is expected to accommodate 90 children when final work on the building has been completed. However, it was opened on a limited scale with 13 students, and formal opening ceremonies will be delayed until the enrollment capacity is reached.

Richard Eddy, Chicago, former superintendent of the Illinois State

Training School for Boys at St. Charles, was appointed by Governor Dwight H. Green on October 15 to be superintendent of the new institution.

The building used for the new hospital-school was leased by the State of Illinois for \$30,000 a year. It is a 130-bed, 8-story building, located at 2551 North Clark Street, Chicago, and was formerly known as the North Chicago Community Hospital.

The staff of the new hospital-school will include doctors, dentists, nurses, dietitians, occupational therapists, and teachers.

Superintendent Eddy said that the new institution will be made as home-like as possible. "Each residential floor," he said, "will have its own playroom and two small dining rooms.

"For the most part only two children will room together, and they will be encouraged to accumulate personal belongings as would a normal child at home.

"In taking the children from their residential floor to special floors set aside for classes, occupational therapy, and recreation," he added, "we hope to give them the same feeling they would have if they were leaving their home to attend school in the community."

SOURCE: The Welfare Bulletin, November 1946. Illinois State Department of Public Welfare.

North Dakota Plans For Its Youth

Representatives of 38 North Dakota organizations met in November at the request of Governor Fred Aandahl to review its youth programs and youth needs. One result of the meeting was the formation of a permanent cooperating group, or conference, of existing State-wide agencies, to be known officially as the "North Dakota Youth Conference." Membership in the Youth Conference will include one representative from each State-wide organization that actively promotes youth welfare. The purpose is:

"(1) To coordinate all youth programs active in the State.

"(2) To disseminate information to the citizenry regarding all youth programs; their aims, activities, and facilities.

"(3) To study the needs of youth in our State."

The standing committees of the Youth Conference are on surveys, public education, public relations, and long-term planning.

The Governor and the State Superintendent of Public Instruction serve with the officers of the conference and the chairmen of the standing committees as the executive committee.

President John W. Headley of Mayville State Teachers College was elected president of the State Youth Conference.

Stella Seurlock.

Teen-Agers and Their Jobs

"Stop, look, and listen if you are thinking of stopping school," is the counsel the National Child Labor Committee offers boys and girls in its new leaflet, "Look Before You Leap" (Pamphlet No. 395, July 1946, 19 pp.).

Briefly and directly, each point driven home by cartoon or pictograph, this leaflet covers what young people need to know about job seeking, educational qualifications, protection against hazardous work, and child-labor laws—State and Federal. A list of recommended standards is given against which young people can check their own State law and any job they plan to take.

"Margin for Living—The 40-Hour Week," also published by the National Child Labor Committee (Pamphlet No. 396, September 1946, 7 pp.) is directed toward civic groups, parents, teachers, youth leaders, health and social workers.

Pointing out that national standards under the Fair Labor Standards Act requiring payment at time-and-a-half rates for work beyond 40 hours a week benefit only those young workers employed in factories, canneries, and similar industries whose goods are shipped across State lines, it calls for local action looking toward State legislation limiting hours of work for all minors under 18 years of age to 40 hours a week and providing comparable standards relating to minimum age for employment, maximum working hours for minors attending school, night-work restrictions, and work-permit requirements.

Miriam Keeler

Kansas Council Looks Toward the Future of Children

After 4 years' study and experimentation, the Kansas Council for Children has recently published its program for child welfare in an 8-page booklet entitled, "What of the Future of the Children of Kansas." Among the council's recommendations are the following:

Boys' and girls' industrial schools should continue to be supervised by the State Board of Social Welfare rather than by the State Board of Administration as has been recommended by the Legislative Council Committee on Institutions. The Council for Children holds that the withdrawal of the industrial schools from the rest of the children's program would constitute a serious setback to the total child welfare program.

The programs of the children's institutions should be revised to provide a curriculum adapted to the needs of the children, special training of a vocational type, and modern emotional and personality therapy.

The aim of such institutions should be to help the child develop into a normal, socially adjusted individual, so that he can take his place in the social group, and be self-sustaining.

The schools in children's institutions should come under the regulation of the State board of education, with school grades given in conformity with public-school practices. To this end the teachers should be certificated and have standard retirement benefits.

A division for exceptional children should be established in the State department of public instruction. This includes the children who are superior and not adequately stimulated or challenged by the regular school program, as well as those who are dull or backward, emotionally disturbed, educationally retarded or physically handicapped.

A center for psychiatric treatment for children under 16 years of age is needed so that mental illness may be treated early. Children placed in the present State hospitals cannot be isolated from the adults and may be seriously affected by them.

The age of minority in juv practice should be extended 18 years.

Marriage laws need revision to prohibit marriage of the physically unfit, and to provide a 3-day waiting period between as a means of restraining persons from entering into unpremeditated marriage.

Child-placing and child-supervising services should be extended. The council recommends home placement as a means of limiting delinquency.

Commission members in other States and child-welfare workers who would be interested in receiving copies of this report can obtain them, free, from the Kansas Council for Children, 335 Jackson St., Topeka, Kansas.

The Kansas Council for Children has had an important part in improving the education and welfare of the children. It began as an outgrowth of the White House Conference on Children in a Democracy, and is composed of leaders of lay organizations, heads of welfare and educational institutions, both State and private, and leading sociologists and psychologists. C. O. Wright, executive secretary of the Kansas State Teachers Association, was elected president of the Kansas Council for Children after the death of Dr. John Geisel last September.

Stella Seurlock.

CONFERENCE CALENDAR

Feb. 5—Social Hygiene Day. Further information from the American Social Hygiene Association, 1790 Broadway, New York 19, N. Y.

Feb. 7-13—Boy Scout Week. Boy Scouts of America, 2 Park Avenue, New York. Theme: "Scouts of the World—Building for Tomorrow."

Feb. 9—Negro History Week. The theme for the year is "Democracy Possible Only Through Brotherhood." Permanent headquarters: Association for the Study of Negro Life and History, Inc., 1538 Ninth Street NW., Washington 1, D. C.

Feb. 17-19—American Orthopsychiatric Association, Cincinnati.

W. S. Grew

diet.⁷ This possibility calls attention to the role of diet in the early weeks of pregnancy and even before conception. Thus preparation for healthy children begins even before they are conceived. Good dietary habits established before marriage and in the early part of married life should pay dividends later. Establishing good food habits is one of the ways in which families can prepare for their children.

When Jimmy and Mary are born they become a part of a family group, where, we hope, they will have love and understanding. Here they learn the meaning of comfort, if their early needs are gratified, or the meaning of discomfort, if they are not gratified. Evidence is accumulating to show that early satisfactions contribute greatly to the ease with which a child meets life later. It is wise, therefore, to adapt the schedules of eating and sleeping to the needs of the individual child. This means watching for clues which indicate his inner needs and using these clues in establishing a schedule. The baby profits both physically and psychologically when he has a good start in life.

In the early years of his life a child spends most of his time in the home. Therefore, it needs to be a safe place, a place in which his physical needs are met, and a place where he will learn good habits and attitudes. The kind of house, the health of others in the family, the family plan of living, and the attitudes of each of the group influence the life of the child. The family food pattern determines the foods which will be served. The child learns to like the foods to which he is accustomed. His sleep habits will depend upon the facilities of the home plus the attitudes and practices of the adults. Meals may be regular or irregular, depending upon the father's and mother's work. Changes in shifts may keep routines from becoming stabilized. In a home where both parents work, not only may life be irregular, but a child may miss the guidance of an adult at an age when he is still unprepared to assume responsibility for himself in the routines of life.

⁷ Anon., Diet and Congenital Malformation, Nutrition Reviews 2: 297-298, 1944.

How does school affect health?

At 5 years of age Mary and Jimmy go to school. There, at first, they spend a few hours, and later, as much as 5 or 6 hours daily, 5 days a week. The school, therefore, is a potent factor in the health of the child.

Jimmy's and Mary's parents have a right to ask certain questions, such as: Does the school offer a healthy environment? The parents may be more specific in their questions. How does the school protect the child from infection? What is its program for recognizing and correcting defects? Are the teachers healthy persons who understand the development and therefore the needs of their children? Are they keenly aware of the early signs of difficulties? Is the lighting adequate? Is it possible for the children to maintain good body balance while sitting at their desks or tables? Is the program planned so that the child has a balance of rest and activity, with time for an adequate lunch and a suitable place to eat it? Is the school fulfilling its part in helping the child to learn about himself and his needs?

If these questions can be answered satisfactorily the school will contribute a great deal to the good life of a child. Neither the school nor the home can carry the full burden. The cooperation of these two forces is necessary so that the child's home and school life are well synchronized.

Jimmy's and Mary's home and school are a part of a community which has certain responsibilities for protecting the well-being of its children. The community can utilize the discoveries of science in protecting the health of its children. It can ensure safe food and water supplies, and programs for protection against accidents and infectious diseases. It can maintain housing standards so that children will not live in unsanitary conditions. Provisions for parks and playgrounds will assure children space for outdoor activity.

Thus Jimmy and Mary, with understanding parents and teachers to guide them, living in an environment which is planned according to the best of man's knowledge, can be free to grow to the fullness of their capacity.

Reprints available on request

MANUAL FOR SCHOOL AND INSTITUTIONAL LUNCHROOMS. Ohio Dietetic Association, 1001 Huron Road, Cleveland 15, Ohio. Revised edition 1946. 222 pp. \$2 single copy; \$1.85 for 3 or more.

This manual, originally published in 1942 as "Manual for Managers of Rural and Other Small School Lunchrooms," has been revised in the light of recent nutrition knowledge but retains the discussions of various phases of school-lunch organization, operation, and integration into the total educational system. Lunchroom operators, school administrators, classroom teachers, public-health workers, home economists, and nutritionists, as well as others interested in the health and education of children, will find their wide variety of interests touched upon. Recipes for 12, 25, and 50 servings, and general information on common food measurements and guides in purchasing, make the manual useful to small and large feeding programs alike.

GUIDE FOR PARENTS OF A PRE-SCHOOL BLIND CHILD, by Gertrude Van den Broek. Commission for the Blind, New York State Department of Social Welfare. Available from the Bureau of Services for the Blind, 205 East Forty-second Street, New York 17. 1945. 48 pp. 15 cents to out-of-State residents.

Of the writing of books about child care in general there is no end, but when it comes to help for parents of children who pose special problems there is scarcely a beginning.

That this simply written booklet is the result of much practical experience is obvious, for it includes just those features of child life about which the parents of a young blind child needs for constructive encouragement. The author points out the differences between such children's needs—physical, emotional, mental, and spiritual—and those of children who can see, without making the special obligation of parents to their blind child seem onerous.

The section on "What to expect of your child" gives, year by year, concrete

ways in which parents may lighten their child's burden, thereby offering much comfort to parents of blind children who wonder if they are "doing all they should."

A brief list of stories and music is included, also a list of books on guidance of the preschool child.

Marion L. Faegre

BIBLIOGRAPHY OF BOOKS FOR CHILDREN. Bulletin of the Association for Childhood Education, 1201 Sixteenth Street NW., Washington 6. 1946. 100 pp. 5 cents.

The present inundation of children's books makes the choosing of one a headache for persons unfamiliar with children's tastes and interests. And it places such a carefully compiled and annotated list as this one, by the Association for Childhood Education, high in the esteem of parents and educators alike.

More than a dozen well-qualified persons have contributed toward making the revised list representative, colorful, and distinguished. Especially welcome to those who are on tiptoe to seize the opportunity of helping children become world-conscious will be the more than 20 pages listing books that foster understanding of our neighbors all over the globe—and next door. A section on family relationships testifies to our growing awareness of the importance of awakening in children appreciation of the values of family life.

Marion L. Faegre

EDUCATIONAL SERVICES FOR YOUNG CHILDREN. Educational Policies Commission, 1201 Sixteenth Street NW., Washington 6, D. C., 1945. 56 pp. 10 cents.

"The first 5 or 6 years of a child's life are the most important that he will ever experience, important and vital because they are first," says the Educational Policies Commission, proposing that school services be extended downward to reach children of 3 or 4 years of age.

The pamphlet describes the educational services now available for some

young children in parts of the United States, such as child accounting; health services; supervised play groups; nursery schools and kindergartens, parent education, including family consultation centers; and special services for rural areas. It discusses the integration of these services with the program of public education as a whole and recommends such integration.

Before such services can be established in a community, financial and legislative support must be considered. And the commission suggests that when need for these services has arisen in a particular community and has received general recognition, the particular services proposed should be tried out. It is the neighborhood and local community which must take the first steps, the pamphlet says, show the first interest, put forth the original effort, and put up the initial funds.

WHAT CAN I DO NOW?: A Handbook of Answers for Parents. Ninth District Inc., California Congress of Parents and Teachers, 645 A Street, San Diego, Calif., 1946. 53 pp. 35 cents.

Typical of what a number of cities are doing to furnish information to parents about local recreational possibilities is this attractive booklet from San Diego, Calif., listing a great variety of leisure-time activities. Under such headings as "The Challenge of Camping," "Family Excursions," and "Home Handcraft," are ideas galore. One summer would be far too short to indulge in more than half of them.

Perhaps the most original section is that on "Family Celebrations and Records," in which Kenneth S. Beam proposes a way of substituting for the security formerly built up in children by their families' long-continued residence in one community. At the present time, when millions of families have moved out of their familiar settings, breaking old ties and carrying with them few of their cherished possessions,

there is need for stimulating in children a sense of family continuity, of pride in their forebears, and in their family name. Mr. Beam's idea might well be taken up by many communities, especially those in which the turnover of population is rapid.

The humorous drawings by Helen Walters will do a lot toward making the booklet more widely read.

Marion L. Faegre

GROWING UP SAFELY. Bulletin of the Association for Childhood Education and the National Commission on Safety Education. National Education Association, 1201 Sixteenth Street NW., Washington 6. 1946. 28 pp. 50 cents.

As the hazards children are exposed to increase, more thought needs to be given to a positive approach to the problem of making desirable activities safe ones, too. This little bulletin reminds teachers and parents that an overcautious attitude may be as productive of trouble as a reckless one, and gives practical suggestions as to how children may be helped to enjoy experiment and adventure through the development of judgment and self-confidence.

Marion L. Faegre

THE HEALTH OF THE SCHOOL CHILD, by Gertrude E. Cromwell, R. N. W. B. Saunders Company, Philadelphia, 1946. 256 pp.

Written primarily for the school nurse, this book centers its discussion around the health needs of the child while at school and methods of meeting those needs.

A chapter on child growth and development gives a basis for understanding the child's needs. The functions of the nurse are discussed with relation to each of the various parts of the health program for school children. Many useful suggestions are given as to how she can fulfill these functions most effectively, such as examples of ways in which she can help teachers to make vital the health instruction for different age groups. Methods of promoting parent participation receive attention throughout, and special chapters are devoted to home-school relationships and community relationships.

Recognizing that there are many unsolved problems of school health administration, the author confines herself to a consideration of the contribution that the school nurse can make in any administrative set-up.

The material presented should be of value, however, not only to the school nurse but to the administrator responsible for developing the health program and for clarifying the responsibilities of the nurse and others concerned in the program.

Marian M. Crane, M. D.

CHILDREN OF THE CUMBERLAND, by Claudia Lewis. Columbia University Press, New York, 1946. 217 pp.

When Miss Lewis went to Tennessee to set up a nursery school for mountain children she had no idea of the serious questions that would arise out of the contrasts between these children and those she had taught in New York City. The book that came out of her observations is thought-provoking indeed, and the method she has used—a study of children in their life situations—has great possibilities for pushing forward the frontiers of our explorations into childhood. Only a person of great "delicacy and sensitive penetration," as the foreword by Barbara Biber suggests, could have revealed these life stories so objectively, and at the same time with sympathy and deep understanding.

Little unforgettable pictures flash into mind: The 5-year-old boy who just naturally stayed home from nursery school to follow his father around when the latter was laid off his job at WPA; the delightful protective cuddling these young children give brothers and sisters just younger than themselves.

All of us who work with children, whatever our setting, or who have children of our own, will find some of our ideas and beliefs being pushed around considerably as we become absorbed in this book. Neat, snug concepts of "adjustment," "security," "aggression," and the like may need a little reshuffling as we begin to ponder the implications of Miss Lewis' observations. She has laid all her cards on the table—we can draw our own conclusions.

Marion L. Faegre

Reprints Available

A limited quantity of each of the following items, reprinted by the Children's Bureau from sources outside the Bureau, are available for distribution. Single copies may be had without charge.

Modern Standards in Adequate Facilities for Obstetric Care. By the Hospital Facilities Section, U. S. Public Health Service and the Division of Research in Child Development, Children's Bureau. *Hospitals*, February 1946.

A National Dental Care Program: Presentation of the Dental Problem. By John T. Fulton, D. D. S. *Journal of the American Dental Association*, October 1945.

Nurseries Designed for Modern Maternity. By P. A. McLendon, M. D. and John Parks, M. D. *Modern Hospital*, July 1945.

Progress in the Care of Premature Infants. By Ethel C. Dunham, M. D. *American Journal of Nursing*, July 1945.

Standard Plans for Nurseries for Newborn. By Ethel C. Dunham, M. D.; Marshall Shaffer; Neil F. MacDonaid. *Hospitals*, April 1943.

Trade Areas as Planning Units. By John T. Fulton, D. D. S. *Journal of the American Dental Association*, April 1946.

A Type Plan for a Pediatric Hospital Unit. By the Hospital Facilities Section, U. S. Public Health Service and the Division of Research in Child Development, Children's Bureau. *Pencil Points-Progressive Architecture*, August 1945.

●
Dickie, on our cover picture this month, is out for a morning spin. Wheel toys like this give a child a lot of pleasure and keep him out in the open air. The photograph was taken by Philip Bonn for the Children's Bureau.

Other credits:

Page 115, photograph by Rebecca Snyder.

Page 116, Library of Congress photograph by Arthur Siegel for OWI.

Page 117, Library of Congress photograph by Esther Babley for OWI.

Page 118, photograph by Peter Sekaer for National Housing Agency.

Page 119, photograph by Arthur Rothstein for FSA.

Page 120, Pennsylvania Department of Health photograph.

For Children and Youth

To Washington, on December 9-11, 1946, came about 100 representatives of national organizations and of States and communities, the members and guests of the National Commission on Children and Youth.

The commission (created in 1942 as the Children's Bureau Commission on Children in Wartime) has met five times as a group. The December meeting was the first since the commission's wartime function had ceased; its new status recognized in the name, *National Commission on Children and Youth*, and a broader membership appointed.

Those who gathered for the meeting came from a wide variety of backgrounds. They voiced contrasting experiences and convictions. But one thing they had in common; they believed in the families, the children, and the youth of America, in our grave responsibility to them—and to the children and youth of the world.

Sparked by the planning of Ronald Lippitt, the meetings began Monday morning. A keynote address by the chairman, Arthur J. Altmeyer, Commissioner for Social Security, Federal Security Agency, and four fighting and factual declarations—by Dr. Henry Helmholtz, Willard Givens, Dr. Ellen Winston, and Mrs. Gertrude Folks Zimand—put the members in form for the 3-day conclave.

The commission organized itself into

four discussion groups that met concurrently. Each addressed itself to problems of method. We asked two questions: "Where are we?" and "What is blocking further development in education, in child-welfare and child-health services, and in abolition of child labor?"

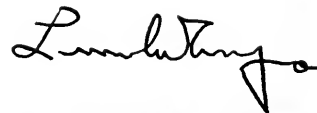
One evening session of the commission as a whole was devoted to international problems of children and youth, and another to methods of working effectively with the 80th Congress.

On the final day the commission heard and passed upon the recommendations of the discussion groups and of several working committees. The substance of these is given elsewhere in this issue of *The Child*. Worthy of special mention are the thoroughly debated and vigorous resolutions calling for more dynamic leadership by the United States in meeting the plight of the young people of other lands, extension of social-security programs to provide a more adequate economic floor for the American family, expansion of child-health (both mental and physical) and child-welfare services, and efforts to prevent violation of child-labor laws. Included also was a ringing declaration in favor of Federal aid for education, particularly in deprived areas, and for extending adequate educational opportunities to the children and youth of all our people.

An outstanding feature of the meeting was the participation of represen-

tatives of nearly a score of State and local commissions and committees on children and youth. Many of them were organized under the stimulation of and with the encouragement of the National Commission. They are, however, ruggedly independent and are proceeding, as they should, in the light of local conditions. They are the commission's lines of communication, through which recommendations are channeled and put to work for the benefit of young people throughout the country. More power to them!

The unique thing about this conference was its spirit. The participants took on tough problems with conviction and resourcefulness. They were practical, but they had their eyes on far horizons. They stressed method as well as goals. They showed unmistakable signs of believing without reservation that our democracy can do far, far better in ensuring a decent life for its children and youth. They revealed a potential spiritual strength, which if expressed by our people in sufficient measure, will save America's soul and in so doing help to cure a sick world.



LEONARD W. MAYO, President,
Child Welfare League of America.

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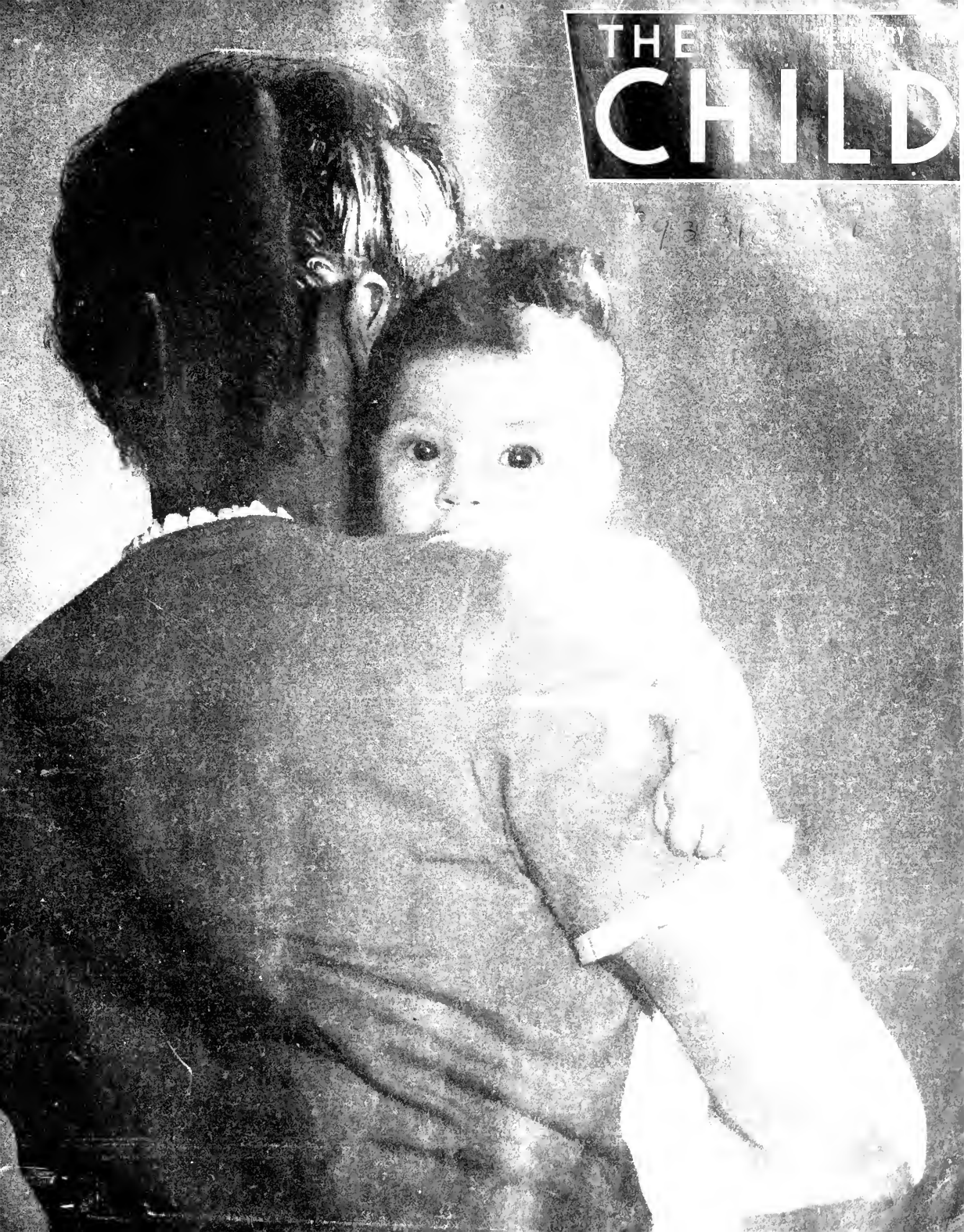
CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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THE CHILD



"Who am I?"

Social agency helping a child to answer this question has a grave responsibility

GRACE LOUISE HUBBARD

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WHO AM I? is a question that cannot be answered completely by any birth record, no matter how expertly devised or carefully handled. Every individual has a right to accurate and complete identification of himself, but he has also the right to understand his identity in its broadest meaning.

Webster's dictionary defines identity as "unity and persistence of personality"—a dynamic concept, implying something that comes from within, something made by the person himself.

A right to our identity really means the right to be able to create for ourselves that degree of unity and persistence of personality that gives us a sense of self-direction, of relatedness to people, and to our environment. It includes what we know about ourselves and about our origin, and also what we have been able to take out of our life experience. Lineage alone does not create one's identity. But to discover suddenly that one's family foundation is not what it has always seemed to be may bring a shock and a need for readjustment.

This experience may sometimes come to a person who was born out of wedlock but has been protected from knowing that fact, whether living with his own relatives or apart from them; or, in fact, to anyone who has been brought up in some form of foster care.

The amount of help available to a young person in this position depends upon what his situation has been in relation to his family and friends, and to the social agency that had a part in determining his early life.

A person who as a child was placed by

a social agency in a foster-family home, whether for adoption or for permanent supervised care, is assured of a record of his origin and identity, and of a source of help in finding out not just what the record shows but what human experience lies behind it.

The agency knew the mother who had to choose how her child would live—with her or apart from her—and is in a position to give him not only the facts but some interpretation of the pressure of circumstances that led to her choice.

A young person who is trying to fuse an unknown past with his present, needs more than to know his ancestry. He wants to know his heritage.

First clue from birth certificate

If he has been completely uninformed about his birth history, he may get his first clue to it from what is recorded or omitted on his birth certificate. He may be made unhappy by what he finds and he may feel that the certificate itself is responsible for his unhappiness because it does not tell him enough. But the real cause of his distress is that he cannot understand the circumstances that created his present situation. There is always a story behind the record, and it is that story that he really wants. Not facts alone, but interpretation of facts, will help him.

Adopted children do not seem, on the whole, to have a very great need to look into their past connections, but when they do the need may be urgent. The workers in my agency have found that a small proportion of children do come back, asking for information about their parents or their lineage in general.

The degree of their interest is related closely to the success of the foster-home experience. Children adopted as infants, who become well integrated into foster homes and have happy, satisfying lives there, do not as a rule feel great concern about their original families.

Sometimes, however, they want to know about themselves, and when this happens their interest may range from a sort of general curiosity about such things as their nationality and the first names of their parents and how they looked, to an active desire to find out all they can, and perhaps even locate and meet their relatives.

My agency has always recognized the right of the child to know about his own family, if he wants to—at a time when he is adequately prepared for the knowledge—and if the foster parents sympathize with his interest and are ready to have him know. The foster parents have a real stake in this, and they have a right, which the agency recognizes, to a share in determining the point at which a child is given the story of his own family and the way in which it is given. This is not a conflict in interest, for the child turns naturally to his foster parents with his first questions, and usually it is through them that he reopens the contact with the agency. In fact the foster parents often make the first move and in doing so seek the help of the social worker for themselves as well as for the child.

Foster parents do need help in this situation, for to them it may seem to threaten destruction of all that they have built up. It reminds them that this child, whom they have made their own, had an origin apart from them. They fear for themselves as well as for the child when they are faced with the necessity for explanations. There is reassurance for the foster parents in the social worker's recognition of the part they have played in the child's consciousness of himself as a person and



Planning to place her baby for adoption, this mother hopes he need never know about his origin. But the social worker who is helping her with her planning explains that the child has a right to his identity, and that it should be preserved for him.

the extent to which this consciousness contributes to his sense of identity.

At the time that war conditions began to require many persons to show proof of age and citizenship, the New York law providing for correction of birth certificates after adoption was relatively new, and many foster parents in that State did not have corrected certificates for their children. Consequently the agency that had placed these children for adoption at least 18 years before received many requests for information. The requests came through foster parents and directly from the grown children. The agency handled all these requests on an individual, case-work basis, and, in recognition of the emotional significance which this renewed contact might have for both child and foster parent, assigned to this service an experienced case worker. This worker made every effort to establish with each individual a relationship based on the assurance of the worker's continuing interest in his achievements and his welfare. Often, but by no means always, a latent concern about family history emerged, revealing a mixture of the wish to know and some dread of what the knowledge would be.

There is bound to be some conflict between the individual's imaginary picture of his unknown parents and the reality. His divided feeling, of hope and fear, may include reluctance to have

the dream picture destroyed and replaced by a reality less agreeable.

The individual may wonder what responsibility he would be expected to take if he should find his relatives in trouble of some sort, or whether he might have to bring them into his present life. He may unconsciously resent his parents' desertion of him. He may never have accepted his separation from them as necessary, particularly if he was old enough to remember it.

At the same time he may be very much interested in knowing why the separation took place, what sort of people his parents really were, and how much he will think of himself as a different person when he has this more complete picture of his origin.

Will he seem a different person?

This will bring him face to face with himself as another person, as the child of parents different from those he has always known and to whom he has given his affection. It is natural for him to wonder whether he can fuse the two aspects of his identity into a coordinated whole, his real self. We can understand that he may want help in getting through a disturbing experience.

The individual who decides that he wants this information arrives at this decision very gradually. Renewal of contact with the agency may have revived for him some earlier desire to de-

fine and clarify his identity. And in the agency worker, whether or not she was the person who actually participated in his placement, he has someone with whom he can discuss his feelings freely and from whom he can get both the information he wants and some interpretation of the situation that led to his separation from his family. The worker knows him as he is now, and represents the agency that knew him even before his foster parents did.

The social worker's responsibility is not only to the young person who is seeking the establishment of some relation with his past, but also to the mother who may be asked to reopen a long-closed chapter of her life. Naturally, the worker will proceed with great caution. The fact that a grown child wants direct contact to see for himself does not necessarily mean that the mother will want it. Even when both want to meet, and when the adoptive parents are in sympathy with this wish, the mother and child need help and support. Much careful preparation must precede any actual meeting.

Such meetings are on the whole infrequent. Unless the foster child's own life has been unusually lacking in emotional relationships, his interest seems to be in the satisfaction of knowing, rather than in trying to rebuild something that never really existed.

When I say that the individual needs help, I do not mean to imply that his learning about the past is necessarily an upsetting experience. The way in which the information is given determines this. The quality of the own parents' interest which went into their original planning for the child, the extent to which their plan represented a genuine desire to obtain security for him and to overcome his early handicap, even the limitations that kept his parents from caring for him—these are important. Little things such as what the mother or father is like, the color of eyes or hair—the things we all know about our own families—help him to get a feeling of his parents as people—of their human attributes—and that is what he really wants.

The situation facing the young man or woman about whose past nothing whatever is known, who was abandoned in infancy, is both easier and harder.

If there is no past, there is no problem of assimilating it into the present, no threat to one's present personality.

On the other hand, it may be difficult to accept the fact that one has no past. Some of these young people find themselves unable for a long time to believe that there is no knowledge anywhere of their origin. The skill of the worker can be used here in helping the individual to realize that the source of true identity is within oneself. What comes out of the past may be strengthening or weakening, but it does not in itself create individuality or identity. It is not easy to feel that one started from nowhere, and must make a life entirely out of one's own living of it. But what comes out of it in ultimate perception and awareness of identity is in the end a self. Thus it was expressed by one who had been through the experience: "When all is said and done, I would not exchange my state for that of any one I know."

The social worker today will recognize, from her first contact with a mother who asks to have her child placed, the responsibility, not only to make the best possible plan for the child, but to preserve for him as fully as possible the information about his heritage. Much of this information will rest undisturbed in the files, but consciousness of our purpose in gathering it together will help us to use it if it is needed.

The worker must bear in mind not only the mother's situation, but also the importance to the child in the future of knowing his mother's feeling about him, and how this entered into the choice the mother made.

At that point the mother herself is rarely able to think much about what the child will know about her in the future. In fact she is apt to hope he will not have to know anything at all. It is a frightening idea to her, for it suggests that the anonymity that she now sees as essential may be destroyed.

If she thinks of the birth certificate, she thinks of it as protection for herself rather than as identification for the child. She wants as little as possible to be on the record, lest it be used accidentally to disclose the facts.

She at first distrusts the social agency, and even though she comes to accept its good faith, she may doubt its power to protect her. She feels that her whole



Margaret was adopted when she was a baby, and she knows it, and feels as much a part of the family as her foster parents' own little girl. A well-adjusted child like Margaret is not likely to worry later in life about her original family.

future is at stake. And if she uses an assumed name when she enters the hospital, and allows it to be put on the birth certificate, we need not wonder why.

The social worker will accept this if necessary. But she will help the mother to see that the agency does have the power and the will to protect her, though it can do this only if she will trust it with her full story.

Concern for child's future comes later

The mother may not realize this while her own problem is foremost in her mind, but after the child is born she begins to be concerned for his future, particularly if she has decided not to be a part of that future. By the time she has come to a decision to place him for adoption, she can understand better his right to his heritage and can help to preserve it for him.

She often feels that it would be better if her child did not know about her in the future, not only because she fears being disgraced, but because she thinks the child will resent her abandonment of him. She usually wishes that he need not know he was adopted, but she often asks whether he will be told this, and also what he will be told about her.

After she has signed a legal surrender she begins to see the child as a person apart from herself, for what happens to him will no longer be happening to

her. Now she can help us to preserve some of her family tradition for the child if and when he wants it. If the case worker and the mother have built up a mutual understanding, the mother will see that she can help the child in the future by telling about the kind of people from whom he comes. The giving of this information to help the child later may also ease some of her feeling that she has failed as a mother by surrendering her child.

It is, of course, harder to get a true picture of the child's paternal ancestry. The mother may not know much about the father, or, if she does, may not tell. But the worker will bear in mind that information about the father is a part of the child's right no less than knowledge about his mother. If we are really convinced of this and can make this conviction a part of our approach, we can hope to show the father, as well as the mother, what comfort the child may get not only from the facts, but from the feeling that he was not cast off, and that his father as well as his mother took part in the effort to get security for him. This is probably of more real value to the child in the long run than legal establishment of paternity or formal acknowledgment of it.

When the child goes into his foster home, the worker sees that the story of his family background—of course with-

out identifying information—goes with him. This is not only to give the foster parents a means of deciding whether or not they want this particular child, but also to help them prepare to answer the questions the child may ask when he is older. In giving this information the worker realizes that the child will turn first to his foster parents for information if he becomes curious about his earlier life. She will try, while giving the essential facts, to give also some evaluation of the parents' feeling in relation to the decision to provide a future for the child through adoption. Foster parents usually do think about this, and when they are taking a child they try to prepare for it, but as time goes on it becomes harder for them to realize it.

Part of the agency's contribution to the child's security—the purpose for

grating the child's past as well as his present into that of the foster family, through letting him understand from the beginning that he has been adopted.

This makes for a very different situation for these children as time goes by, and it will be much less often that a young adolescent discovers suddenly, and probably at a time of some family crisis, that he has been adopted.

Having grown up knowing that he was adopted, having been free to talk of this with his foster parents while he was growing up, his need for a more detailed picture of the past will be less important. Or if it becomes important, the reasons will be clearer.

Because the agency carries its conviction of the child's right to his identity in the largest sense into each stage of its care and planning for the child,

of this group we know little as they grow up, for the social agency that aids the mother at the time of the child's birth rarely continues to be in contact with her until the child is grown. Thus there is less chance to help either the mother or the child with the eventual questions concerning his birth and his real father. But such children are likely also to have less need of this kind of help. Some do not ever have to face the facts of their birth. Others do, and face it without the help they need. Yet, even so, their situation is easier than that of the child who has been completely cut off from his family.

If the mother plans to surrender her child for adoption, the agency focuses its interpretation primarily on something that, when it actually occurs, will not be a part of the mother's own experience.

If, on the other hand, she is keeping her child, and she herself is to be the one to answer his questions, her attitude will depend largely on the extent to which she has integrated herself and her child into her own community, and her own feeling toward the father. She may simply tell the child the truth. Or she may say that the father is dead, because that represents her own feeling. We can be sure that it will be, not the facts themselves, but the values given them in the telling, that will determine the child's response.

When a child asks, "Who am I?" he does need to know his name and lineage, but what he is really seeking is to sustain his awareness of self so that he can achieve a unity and persistence of personality, in spite of the break in the continuity of his life. This is his right, a right that we are under obligation to secure to him to the greatest extent we can.

Careful and accurate recording of one's birth is a basic step, and the right of every person. But a sense of one's heritage is also every person's right, and if a child does not have his own parents to give him a sense of his heritage as well as his birth identification, interpretation should be given by someone with understanding, as well as knowledge, of the facts.

A child's identity is his sacred right.

Condensed from paper given May 23, 1946, at the National Conference of Social Work, Buffalo, N. Y.

Reprints available on request



Ted has learned from his birth certificate that the parents he has always known are not his real parents. A member of the staff of the social agency that helped his mother to plan for his adoption 18 years ago is telling him about his original family.

which he was originally placed—is to strengthen and build up the bond between the child and his foster parents and to treat the story of the child's earlier life so that it becomes a part of experience shared with his foster parents rather than something differentiating him from them. The foster parents, particularly in the child's early life, largely determine when and how his questions are answered—in fact, they are often a factor in determining whether questions are ever asked.

Social agencies place greater emphasis now on the importance of inte-

it does much to prevent the anxiety and apprehension that we have found in persons who were separated from their own families without knowing why.

We do not, of course, know how many children born out of wedlock are kept by their own parents, or at least by the mother, and grow up within their natural family groups, but the majority are so kept.

Some of these children eventually have fairly complete family life, when the mother marries the actual father or another man who accepts more or less genuinely the fatherhood of the child.

PUBLIC HOUSING IN CHICAGO BENEFITS FUTURE CITIZENS

J. S. FUERST, Chief of Statistics, Chicago Housing Authority

PROVIDING GOOD HOUSING for Chicago's children is a primary objective of the Chicago Housing Authority. At present, in the 7,350 low-rent dwelling units, upward of 31,000 persons of all races and creeds are housed. Of these, 18,000 are under 21 years of age.

Five of the projects house 3,000 persons each. Like five towns in the United States, these projects are small communities in themselves.

Altgeld Gardens, one of the largest, houses over 1,450 families, with more than 4,000 children. In this project have been developed many of those services that go into the making of a community—a nursery school, an elementary school, a high school, a prenatal clinic and an infant-welfare station operated by the city board of health, a branch of the public library, a church, a consumer cooperative, a community-activities building, and many playgrounds. The parents have such groups as parent-teacher associations, tenant councils, consumer cooperatives, dramatic clubs, arts and crafts groups, and project newspapers. The children have similar activities. There is a glee club in Bridgeport Homes and a youth council in Ida B. Wells project, and a boy-scout and a girl-scout troop in almost every project.

The projects have been aptly called "children's cities." More than half of the residents are children. In some of the projects 6 out of every 10 persons are children. The proportion of children is much greater than in Chicago families generally. For example, in a recent sample of congested Chicago blocks there were 1,200 children in 1,000 families. In another 1,000 families chosen at random in the Chicago Housing Authority projects, there are 2,300 children. About half the families in the projects have either two or three children, and about one-fourth of the families have four or more.

At Altgeld Gardens and at Robert Brooks Homes, almost one-third of the families have four or more children. Families with no minor children are not admitted except for a few couples receiving old-age assistance. The 9 percent of families with no minor children are largely those who, though they have been notified that they are ineligible because their children have reached the age of 21, have been permitted to remain in the project.

For example, proportionately many more children under 10 and fewer children over 14 years of age than in the city as a whole.

Planning in which children are to be given special consideration involves orientation of policies regarding construction, intake, rental, and maintenance.

A primary factor in construction for a large number of children is the size of the dwelling. The first units constructed at Jane Addams project averaged three and one-half rooms per dwelling unit. It was recognized that the larger families were those that suffered most from bad housing. The average size of units was therefore increased with the building of each succeeding project. Altgeld Gardens has an average of more than five rooms



More fun with the spray pool on a sizzling hot July afternoon for the children who live in Jane Addams Houses.

The ages of the children also reflect the attempts of the housing authority to serve young children. At initial occupancy in the projects the average age of the children was about 5 years. Most of the first tenants are still residents today, and the average age of the children is therefore slightly higher than it was originally. The average age of children (8½ years) in the projects is still considerably less than the average age of children in Chicago. There are,

per unit; and the most recent project to be constructed, Wentworth Gardens has almost five rooms per unit or about three bedrooms per family. (The average number of rooms per dwelling unit in Chicago today is less than four and one-sixth.)

Interior and exterior design are also important in housing projects for children. In the housing authority's development plans, for example, play space for the use of children of different

ages is allocated for each group of buildings, and of course the more children housed the more play space is necessary. The newest project is presently being developed with six- and eight-story apartment buildings. Play space has been planned there for children on every floor so that very young children are able to play just outside the door of the family's apartment.

Providing numerous outdoor playgrounds is vital for children. However, with limited space available, the more playground space the less opportunities for greenery. A development looks most homelike and attractive where there is an abundance of grass, trees, shrubs, and flowers, but many factors must be considered. Preschool and grade-school children are hard on landscaping. Space that can be purchased is limited. It is agreed that the appearance of the project must be maintained. Therefore, it becomes a question of balancing the advantages of playgrounds against the additional maintenance costs of greenery.

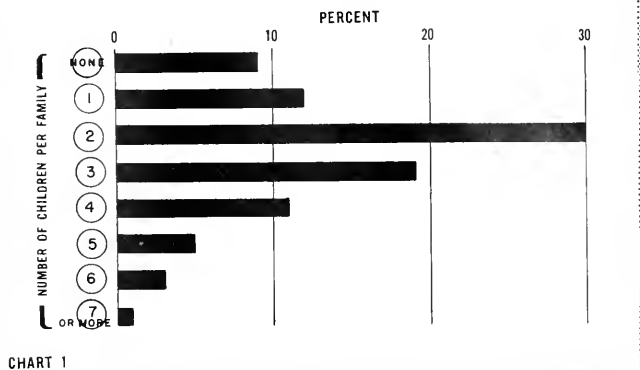
Expenditures limited by statute

All these special considerations cost additional money. Building larger dwelling units and building more inside recreational space increase the cost per unit. Similarly, providing more outside playgrounds for additional children requires the purchasing of more land. This is particularly important because, as explained below, families in larger units do not yield more rental income. The outside limit to such construction expenditures is that imposed by statute under the United States Housing Act. Even before this limitation is reached, however, any authority must carefully consider to what extent additional funds can be expended for development to provide these benefits for children.

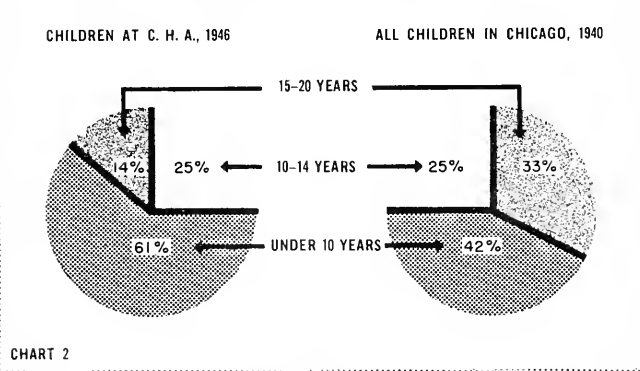
Larger families omitted

In the earlier projects the average dwelling-unit size was only about three and one-half rooms; but an attempt was made to bring in as many children as possible. As the average dwelling-unit size was increased, larger families were admitted. At present in a six-and-one-

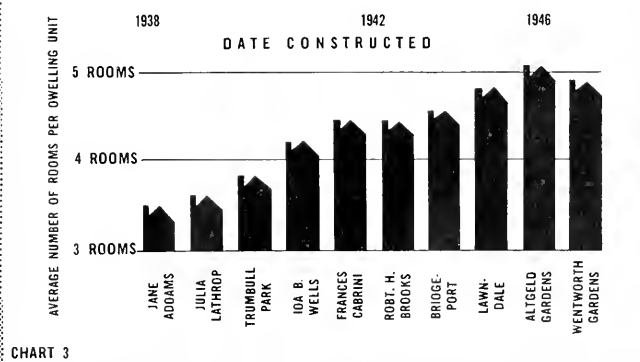
PERCENT DISTRIBUTION BY NUMBER OF CHILDREN IN FAMILY, OF FAMILIES LIVING IN LOW-RENT PROJECTS OPERATED BY THE CHICAGO HOUSING AUTHORITY, 1946



PERCENT DISTRIBUTION BY AGE OF CHILDREN IN LOW-RENT HOUSING PROJECTS OPERATED BY THE CHICAGO HOUSING AUTHORITY, 1946 AND AGES OF CHILDREN IN CHICAGO, 1940



AVERAGE NUMBER OF ROOMS PER DWELLING UNIT OF LOW-RENT PROJECTS OPERATED BY THE CHICAGO HOUSING AUTHORITY IN ORDER OF CONSTRUCTION DATE



half room apartment with four bedrooms, families with as many as seven children may be admitted.

This policy has important implications for the number of persons per room. Overcrowding is one of the most serious slum problems that public housing seeks to correct. This overcrowding particularly affects families with many children. A description of the previous living conditions of a few of the tenants

many of the residents have come to the present living conditions in the projects. The units house an average of one person to a room, and in the projects with many children the number rises to the average of one and one-quarter persons per room. In Lawndale Gardens, where every unit has either two or three bedrooms, the average is considerably less than one person per room. Here, one-quarter of the families include only

selves among the most fortunate in the projects.

The authority's concern with the needs of families with many children has particularly affected rent policies. In private-enterprise housing such families usually have to pay more rent than smaller families, despite the fact that the larger families frequently have less income.

When the Chicago Housing Authority began operations, flat rents were charged the tenants and, as with private enterprise, larger units rented for more money than smaller units. After a few years' experience with this type of rent schedule, a new schedule of rentals was devised in which rent was adjusted to income, with slight differentials for family size. Thus a family with \$1,300 annual income and one child, occupying a three-room apartment, paid \$25 for rent. A family with the same income and six children, occupying a larger apartment, paid \$28 or slightly more per month.

Although this pattern of rents was considerably fairer to larger families than the previous one, it was still not equitable. Families with the same income who needed larger apartments paid more than did the smaller families. Moreover, because these larger families had more expenses they actually could afford less rather than more for rent.

Recently a rent schedule was adopted under which residents are given apartments in accordance with their needs, and pay rentals roughly in accordance with their income. Moreover, the exact rent paid is weighted inversely with the number of children in the family. For example, a family with five children and an income of \$1,375 pays \$24 for a six-room apartment, while a family with the same income and only one child pays more rent (\$27) for a smaller apartment. Thus the large family is not compelled to skimp on its food budget in order to pay high rent.

There are a great many benefits that accrue indirectly to the residents of a housing project. Many of these occur because the project comes to have a community life of its own, a unity around which activities may center.

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These little boy and girl neighbors like to gather daily in one of the grassy front yards at Frances Cabrini Homes.

in Chicago Housing Authority projects may be helpful in placing in its proper perspective the problem facing a housing authority.

1. A veteran was living with his wife and three children, his parents, and three younger brothers, constituting 10 persons in a 2-bedroom flat.

2. The wife of a serviceman was living with her own four children, ranging from 2 to 10 years of age, along with her husband's family, consisting of four adults and one child, in a four-room flat.

3. A husband, his wife, and three children, ages 2, 3, and 4, were eating, sleeping, and living in one room.

4. A 24-year-old mother and her three children, together with the mother's sister, were living in a one-room and kitchenette apartment.

Compare these situations from which

three persons, usually consisting of a father, mother, and child. They live in a four-room unit, with a bedroom for the child as well as one for the parents.

A housing authority must determine whether it can maintain throughout the projects the ideal arrangements indicated at Lawndale Gardens or must temporarily yield to the overcrowded housing situation in the community.

Because hardship cases are the rule rather than the exception, the number of persons per room in most of our projects is still higher than ideally or ultimately desired. For example, families with six or seven children are admitted into six-room apartments. The difference, however, between these accommodations and the accommodations from which these residents came is striking. In spite of the slight overcrowding, these larger families consider them-

UNITED NATIONS ESTABLISHES INTERNATIONAL CHILDREN'S EMERGENCY FUND

KATHARINE F. LENROOT, *Chief, U. S. Children's Bureau*

JUST A FEW DAYS before Christmas 1946, the first steps were taken in the organization of the International Children's Emergency Fund authorized by the General Assembly of the United Nations on December 11, 1946. The first meeting of the Executive Board of the Fund, composed of representatives of 25 countries named in the resolution of the General Assembly, was held December 19. On January 7, Dr. Ludwig Rajchman, representative of Poland, was elected chairman. The following day Maurice Pate was named executive director by Trygve Lie, Secretary General of the United Nations, who acted after consultation with the Executive Board, in accordance with the terms of the resolution establishing the Fund.

As the Executive Director of the Fund, Mr. Pate, a United States citizen with extensive experience in war and postwar child-relief work overseas, has before him the work of organizing and administering the Fund in accordance with policies laid down by the Executive Board, within the framework of principles established by the United Nations Economic and Social Council and its Social Commission.

For victims of aggression

The Fund is to be utilized and administered, to the extent of its available resources, for the following purposes, as defined by the resolution creating it:

- a. For the benefit of children and adolescents of countries which were victims of aggression, and in order to assist in their rehabilitation;
- b. For the benefit of children and adolescents of countries at present receiving assistance from the United Nations Relief and Rehabilitation Administration;
- c. For child-health purposes generally, giving high priority to the children of countries victims of aggression.

The Fund will not be able to begin operations until substantial financial resources are made available to it. It is of the utmost importance that voluntary agencies receiving contributions from American citizens continue to operate and that full support be given to their activities. The resolution creating the Fund provides that the Fund shall appeal to all voluntary relief agencies to continue and intensify their activities and shall take the necessary measures in order to cooperate with these agencies. The Fund itself will not make direct appeals for individual contributions. Persons in any country wishing to contribute immediately to the relief of children abroad should make their contributions to existing agencies already operating programs.

Millions of children depended on UNRRA

First steps toward the creation of this new international agency, whose effective operation is of such great importance to the lives and health of the children in war-devastated countries, were taken in Geneva, Switzerland, last August. The Council of the United Nations Relief and Rehabilitation Administration, in session there, was considering the policies to be followed in the winding up of its activities. The members of the Council were anxious about what would happen to the millions of children in Europe and China who had depended upon UNRRA for food and other assistance. Accordingly a resolution (No. 103) was adopted authorizing the use of such UNRRA assets as the central committee may determine to be available after completion of the work of that organization, for the benefit of children and adolescents. The resolution suggested that such purpose might effectively and appropriately be served by the creation of an International Children's Fund. A standing committee was appointed to prepare recommendations, in agreement with the Economic and Social

Council of the United Nations, and after consultation with specialized agencies and other organizations.

The Economic and Social Council of the United Nations on September 30, 1946, decided to recommend to the General Assembly the establishment of an International Children's Emergency Fund. In accordance with the terms of this resolution, a plan was drawn up by the Secretary General of the United Nations in consultation with representatives of United Nations and UNRRA officials, for presentation to the General Assembly. After careful consideration by a subcommittee of the Third Committee of the Assembly, on which the United States was represented by Mrs. Eleanor Roosevelt, a report was drawn up which included a draft resolution establishing the International Children's Emergency Fund. This resolution, after approval by the Third and the Fifth Committees, was adopted by the General Assembly.

How ensure children's survival?

A report of the subcommittee took note of the situation with which Europe and parts of Asia will be faced in the next few years insofar as it affects the rehabilitation of children: A general shortage of essential foodstuffs, affecting even countries that were exporters of food before the war; and the difficulties experienced by many countries victims of aggression in securing by means of export or loans foreign exchange indispensable for obtaining imports of foods sufficient to maintain a physiological minimum for the children. The report states, further:

"The children of Europe and China were not only deprived of food for several cruel years but lived in a state of constant terror, witnesses of the massacre of civilians and of the horrors of scientific warfare, and exposed to the progressive lowering of standards of social conduct. The urgent problem facing the United Nations is how to ensure the survival of these children. Millions of adults have emerged from the war less fit to meet the grave problems of the day than in 1939. The hope of the world rests in the coming generation."

In developing plans for the operation of the Fund, the program committee of

(Continued on page 143)

A CITY IMPROVES DAY CARE FOR ITS CHILDREN

We are presenting this story of the work of the Day Care Unit of New York City's Health Department because the program described is unusual—perhaps unique. The New York Department of Health shows imagination and versatility in its efforts to meet the needs of children over and above their physical requirements.

The information is taken from a report published by the Child Welfare League of America under the title, "The Day Care of Little Children in a Big City" (New York, 1946, 33 pp.).

In a foreword to the report, Howard W. Hopkirk, Executive Director of the Child Welfare League of America, says of this work: "Consistent progress in bringing together the services of educators, nurses, physicians, sanitarians, nutritionists, and social workers makes this a service from which lessons may be learned by those in many fields who are today making practical efforts to bring the various professions together and to raise standards of care given young children."

FOR GENERATIONS many of New York City's young children have spent all or part of their day in some kind of child-care center while their mothers went out to work, and even today some nurseries are operating that opened their doors more than a hundred years ago. These, of course, are only a few of the 400 nurseries—more than half of them commercial—that now care for some 18,000 children under 6 years of age, with help from the Day Care Unit of New York City's Department of Health.

Three years ago, when the war emergency was spotlighting the need of children for daytime care while their mothers went out to work, the authorities in New York found that they did not know how many day-care centers or nurseries were in operation, nor how many children were being cared for in them, nor what kind of treatment the children were getting. They knew only that more than 200 nurseries had been granted permits by the city health department, and therefore that these had been inspected by that department, as required by the municipal regulations.

But the code regulating day-care centers or nurseries at this time (1942) had been planned in an earlier day, and covered only sanitation, building stand-

ards, protection against fire, and prevention of disease.

And since that earlier day we have learned much more about other important needs of children. We have learned how important the early years of children's lives are in shaping the adults of tomorrow. We have learned much more about how children develop, not only physically, but also mentally and emotionally, and what helps—and what hinders—the various aspects of children's development. We realize better how differently a child's personality will develop under the influence of various kinds of adults. We have learned these things from such workers as psychiatrists, pediatricians, educators, social workers, public-health nurses, and nutritionists. And we have come to realize that anyone who takes care of children should have the opportunity of getting help from workers in many fields.

It was clear to the health department that if the centers were to be carried on for the best interests of the children, the standards for day nurseries, as expressed in the code, would have to be reexamined in the light of contemporary knowledge of young children's needs.

And so the director of the health de-

partment's bureau of child hygiene, seeking the best in professional opinion, turned to representative groups of experts in a number of fields. Together they worked on the problem of framing recommendations to the department of health for the revision of the existing code.

They recommended a set of regulations that were planned to help inspectors from the health department to evaluate a center in terms of the total care given, and to judge this care on the basis of what research has shown is necessary for the proper growth and development of young children.

The regulations that this group recommended were approved by the health department in February 1943, and are now part of the sanitary code, under which the health department inspects day-care centers and issues permits for their establishment or continuance. The standards set forth are not as high as they might be, as the war emergency demanded immediate care for vast numbers of children, and a working compromise was needed, but it is hoped to raise them later.

Operating without a license

By the time the regulations had been set up, a survey of the existing agencies in the city that were giving day care to children under 6 had been completed by the bureau of child hygiene, with the cooperation of many organizations and some citizens' groups. Nearly 500 such agencies were found. Nearly half of these were operating without ever having applied for a license and without having been inspected by the health department.

The day-care agencies were operated by private individuals, schools, social agencies, religious groups, community centers, and cooperative groups of parents. Less than half were nonprofit agencies.

The motives behind the operation of the agencies were varied. Some nurseries were an integral part of a long-range educational program, and in addition

served the research and teacher-training programs of an educational institution. Some had religious purposes. Others were established solely for commercial reasons, to provide a comfortable living for the owner, or to eke out a meager one. In such instances the success or failure of the venture was measured in terms of the profit made. In some centers the fees were high, and not commensurate with the type of care given. In some, totally unqualified men and women took in children by the day as a sideline to caring for their own families. They would send the children out to play, unsupervised and in all kinds of weather and later, when the housework was done, reluctantly admit them again.

Day care was given in all sorts of places—in private dwellings, vacant stores, cellars, converted factories, churches, schools, and a variety of housing projects and institutions. Saddest of all, perhaps, were those presenting an impressive and attractive front, and offering behind this facade only bleakness, neglect, and even abuse of children.

Some of the nurseries had been operating for a century; some had sprung up in mushroom fashion to meet wartime demands.

As for the care provided for the children, the report describes it as ranging from "excellent" through "substandard and mediocre" to "utterly wretched."

In the centers described as "excellent" qualified and experienced teachers were

alert to each child's needs. Careful planning for good living promoted the growth and development of the children. The atmosphere was friendly, busy, and happy.

There were things to push and pull, and big equipment to climb and hang on so that children's large muscles got the exercise they needed. Materials were appropriate to the ages of the children, and sufficient for the number in the groups. There were the things children needed to play with: Blocks, paints, clay, sand, water, drums, bells, house-keeping toys.

The use of equipment was planned by teachers to develop children's imagination, personality, and intellect. Toilets, chairs, tables, spoons were a comfortable size for children. Equipment was safe.

Premises too were clean, safe, well-ventilated, well lighted, and without fire hazards.

Good nurseries were in the minority

Unfortunately, the nurseries that met all the recognized good standards were in the minority.

In some unsafe quarters, abounding in fire hazards, were found some nursery programs that were excellent as programs.

Some centers, regardless of the size of their premises, accepted children of all ages—from infants to children old enough to enter primary school.

In very few centers was there a close relationship between home and center, with a daily exchange of pertinent information and a growing apprecia-

tion of how home and nursery can co-operate. At most of the centers parents and nursery staff never met. Neither knew what kind of care the other was giving. A child might be getting twice the amount of cod-liver oil he needed, or none at all.

Fee not an index of quality

The fees varied from no charge at all, or only a few cents a day, to as much as \$125 a month. The amount of fee paid was not an index to the quality of care given.

Some centers were closely affiliated with one or a number of professional or other organizations; but the majority had no outside contacts and struggled along in a vacuum. This was particularly true of those run primarily for profit, though philanthropic nurseries often faced the same problem.

In many nurseries care was substandard and mediocre. In others it was utterly wretched; no toys or other play equipment, no rest, no decent food, no concern for health, safety, cleanliness, or joy; nothing but an adult "minding" children in a barren room.

A few nurseries prided themselves on "breaking a child's will," and the shouting, threatening voices of the adults were reinforced by physical punishment. In these centers were the adults who complained bitterly about children's "defiance" and "destructiveness."

In some centers a few children sat all day, listless, quiet, speaking only when spoken to. Others were so overcrowded that children from 2 to 6 years of age

Tools are fun, and this center has small-sized ones that help the children to develop skills.



City children have few pets, and these day-nursery youngsters think Peter Rabbit is wonderful.



milled in one confused, tiring group. Every moment of the long day was over-organized; every child was forced to take part in every song, game, and story. When exhausted 2-year-olds fell asleep, they were prodded awake and forced to join in again.

City to protect children

By July 1, 1943, with a census of existing nurseries, with the legal requirement that they all apply or re-apply for a license, and with an improved set of standards incorporated into the municipal regulations, it was possible for the city to provide protection for the children in nurseries by exercising a measure of control over the center caring for them. And it became clear that the health department needed an adequate staff to investigate, advise, and assist the existing 500 agencies and the new ones that would undoubtedly be formed.

To meet this need the day-care unit, within the health department's bureau of child hygiene, was formed, with a professional staff of six workers: The director, whose background was in nursery education; a social worker; a health consultant; and three public-health nurses who had additional background in nursery education and work with young children. A private organization provided money for additional expert personnel.

Joined in a common effort

The health department provided public-health nurses, sanitary inspectors, nutritionists, stenographic service, space, and office supplies.

Inspectors from the fire department, the bureau of sanitary engineering, and the department of housing and buildings have visited each nursery.

Here now, joined together in a common effort, are specialists from many fields; each has contributed a valuable point of view concerning the care of young children.

Before the establishment of the day-care unit, nurseries were usually granted permits without any outside agency being consulted. But it seems almost obvious that many agencies in the city that are working to improve group living for children could contribute much to the improvement of



After her nap, Loretta is now learning to make her little bed. At all good day nurseries the children get the rest they need.

day-care centers. Such agencies include professional organizations, community and civic groups, churches, synagogues, religious orders, settlement houses, and cooperative groups of parents.

The staff of the day-care unit has met with these groups, and patterns for working together have been evolving. Some of these groups accept supervisory responsibilities for their member agencies; this lessens the load for the day-care unit.

In approaching an individual agency, as a rule, initial inspections are made by the health-department staff. Then joint meetings are held with the co-operating groups, and a program is mapped out for the nursery.

Educational consultants help

Further help was needed by the unit, and aid was sought of the Advisory Committee on the Education of Young Children, which is composed of many of the city's well-qualified nursery-school teachers. A plan was developed whereby part-time educational consultants began to help. These are directors or teachers in private nursery schools with good programs, who left their regular work for some part of each week, or took leave for a period of time, or otherwise found time to render pro-

fessional assistance to a given nursery, staying with it until standards were met. At first these educational consultants gave their services without charge or were paid by the nursery. Now they are paid by the health department.

Officials from two State departments, the department of education and the department of social welfare, have given valuable assistance. Joint visits to nurseries have been made by representatives of these departments with members of the staff of the day-care unit when tangled situations needed thorough review.

New York's day-care unit has as its function to require that children in day-care centers shall have (1) a clean, safe place where they can run, sleep, and sit comfortably; (2) food in accordance with their needs; (3) equipment that permits the play that is right for children's growth; (4) a program that allows for fun and for exercise and rest; (5) care for their health and well-being; and (6) trained teachers who have insight and warmth.

These are the objectives of the New York Department of Health's Day Care Unit, without regard to a child's race, color, or creed, or the economic status of his parents.

SWEDEN WORKS FOR MATERNAL AND CHILD HEALTH

ANNA KALET SMITH, *Office of the Chief, U. S. Children's Bureau*

Europe's critical situation in recent years has not interfered with social progress in Sweden, particularly in the field of maternal and child health. A glance at the developments in that country during the last 10 years shows a consistent Government policy of financial aid to health services, with consequent improvement of standards and expansion of work. With this aid Sweden has built up an impressive health system, of prenatal care and childbirth attendance, maternity benefits, child-health clinics, medical supervision over school children's health, mental-health and guidance services, and dental care for children and adults.

Prenatal care

Prenatal care is given free at clinics, where women are not only examined during pregnancy but are also treated for any complications not requiring hospital care. Grants for this purpose were made by the Government to some counties as an experiment in 1931. With evidence of public appreciation of this service, the aid was extended to all counties and to independent cities and was made permanent in 1937. Under the regulations of 1944 this aid covers (1) up to half the cost of setting up and equipping the clinics; (2) part of the salaries of physicians, midwives, and nurses; (3) from 50 to 70 percent of specified travel expenses of physicians, nurses, and midwives, and also, in some circumstances, of patients. After plans for the work have been approved by the public health authorities, aid is given on condition that the services are free to any woman, regardless of income, that every prenatal clinic is directed by a physician—obstetrician, gynecologist, or general practitioner—assisted by midwives or nurses.

Attendance at childbirth

Attendance at childbirth in the home by trained midwives has been available without charge since 1937 and is now

regulated by a decree issued in 1943. Each county and independent city, with some exceptions, constitutes a "midwifery district," under the control of a board of midwifery and with a prescribed number of fulltime midwives. These midwives work under the immediate supervision of the local medical officer.

ever a midwife serves more than 3 months of a calendar year in a Government-subsidized maternity hospital, the Government pays half her salary, and the rest is paid by the local authorities. The midwife is also entitled to specified promotions, 30 days of annual leave, and medical care in illness. The county or independent city provides her



With Government aid, Swedish counties and independent cities have free child-health centers for babies and little children.

The midwives are required to attend women at childbirth in the home, also during pregnancy and in the postnatal period, under conditions set by law. No charge may be made by a midwife to the patient, regardless of the latter's economic status, but if the patient lives beyond a specified distance she must provide the midwife's transportation. On conditions prescribed by the local board of midwifery the district midwives may also serve in public maternity hospitals and prenatal clinics, or in private ones that are subsidized by the Government.

The salaries of the district midwives are paid by the Government; but when-

ever a midwife serves more than 3 months of a calendar year in a Government-subsidized maternity hospital, the Government pays half her salary, and the rest is paid by the local authorities.

The midwife is also entitled to specified promotions, 30 days of annual leave, and medical care in illness. The county or independent city provides her

Maternity benefits

The Government pays a maternity benefit to women belonging to sickness insurance organizations, in addition to the benefit paid by the organization. A woman who is not insured receives the same Government aid, but only if

her income is below a specified amount. The benefits are paid through the local insurance organization, which is required by a law of 1937 to provide advice and information on care during pregnancy, confinement, and the post-natal period, and care of the newborn child.

If additional financial aid is needed by a woman at the time of childbirth or within 9 months afterward she may apply for it, and may be granted either a loan without interest, or a gift. Sometimes cash is given, but more often orders for clothing or other necessities are issued or rent is paid. The decision as to the amount of aid is made on the merits of each case. "Mothers' aid councils" have been established to take part in the administration of this law. Social workers in public service make sure that the aid is used properly and that the mother brings the child regularly to the child-health center.

Child-health centers

Child-health centers for babies and little children are maintained with Government aid by counties and independent cities. The conditions for the aid, prescribed in 1944, are: The centers must give their services free of charge. They must be situated in suitable quarters, preferably in a children's hospital or the pediatric department of a general hospital, and must be directed by a physician, who is assisted by nurses. A child-health center may be combined with a prenatal clinic, in which case the work for children must be done separately.

In Stockholm and a few other cities the centers are open to children up to the age of 6 years; elsewhere the age limit is lower.

In rural localities similar work is done by "child-care stations" or "maternal- and child-care stations," or branches of such stations.

Both for work in cities and in rural districts the counties and independent cities receive Government aid after a plan for the proposed work has been presented to designated authorities and approved by them. The Government contributes up to half the cost of installing and equipping the child-health centers; and part of the physicians' and the nurses' salaries. It also pays part of the traveling expenses of physicians

and nurses and of mothers who bring children from a distance.

Physical examinations in schools

Much attention is given by the Government to the protection of school children's health through physical examinations, and, in some cases, treatment. (See "Sweden Improves School Health Work," *The Child*, September 1946.)

School lunches

Sweden has now a national program of school lunches for all children in nearly all schools. The history of school lunches in the country dates back to 1845, when they were introduced in a few cities by means of private or municipal funds. Since 1937 Government aid has been granted for this purpose on a small scale, but in increasing amounts. By a law of June 28, 1946, full operation under which is expected by 1951, aid has been made available to all school districts and municipalities for lunches in primary, intermediate, and high schools, continuation schools, and technical schools.

The Government contributes a large part of the cost of the lunches and equipment. The aid is given on condition (1) that the lunches include a cooked dish, with bread, butter, and milk, and are available free for all school children; (2) that the food is prepared and served in suitable quarters; (3) that the persons employed in the preparation and service have a physician's certificate of freedom from transmissible or incapacitating disease and are examined annually, at the beginning of the school year.

To encourage the speeding up of the program the Government gives aid to all school districts that begin to serve lunches by June 30, 1951, even if the meals are served not to all school children as required by law, but to certain groups. These groups include children who live at a long distance from school, or are undernourished or in poor health, or who come from low-income families, or who otherwise could not have a nourishing noontime meal at home.

Child guidance and mental health

Establishment of child-guidance clinics and children's psychiatric clinics

has been facilitated by Government aid, which has been available since 1945 to counties and independent cities. The aid is given after the plan of work has been approved by specified public health authorities. Each county or city receiving the aid must have a central clinic, with one or more branches and a sufficient number of hospital beds for mental patients. The clinics are directed by physicians specially qualified for the work, who are assisted by trained personnel. The aid consists of about half of the physicians' and assistants' salaries and traveling expenses, and is available on the condition that all services at the clinic—examinations, consultations, and treatment—are given free of charge.

Dental care

In an effort to extend dental care to all the people, the Government since 1939 has been paying to counties and independent cities the cost of installing dental clinics and about half the salaries of dentists and dental assistants in those clinics. The setting up of traveling dental clinics is also permitted. Annual examinations are required for children between the ages of 3 and 15; these children are also given any necessary treatment. A small annual fee is charged for the first child in the family; it decreases for the second and third; no charge is made for additional children. Persons more than 15 years of age are charged a nominal fee, according to a schedule, for each kind of treatment. No charge is made to persons who are unable to pay.

It at the time a child enters school his teeth are found to have been neglected and in need of treatment, the parents are required to pay for it at an additional charge.

Compulsory sickness insurance

Compulsory sickness insurance, with medical care and cash benefits, is to replace, under a law of December 18, 1946, the present system of voluntary insurance. The law is expected to go into operation in 1950.

SOURCE. *Svensk Författningssamling*, 1937 through July 1946; *Barnavårdslagen med Tillhörande Författningar*, by Gunnar Wetterburg, Hakan Ohlssons Boktryckeri, Lund, 1945, 324 p.; *Tidskrift för Barnavård och Ungdomsskydd*, 1938 through No. 5, 1946; and *Societal Meddelanden*, Nos. 1-10, 1946.

Children's Fund

(Continued from page 137)

the Executive Board took into consideration the following:

a. The need of millions of children for supplementary feeding.

The report of the subcommittee of the General Assembly called attention to the urgent importance of supplementing food supplies so as to meet more fully the food needs of children. Some 5,000,000 urban children in seven European countries were being given one meal a day in 1946 from supplies provided by UNRRA. "A desirable objective for each government," the report states, "is to ensure one square meal a day to children that can be easily reached, i. e., those in schools and institutions, and the children of families receiving social-security assistance." It is estimated that a meal of 700 calories a day would cost \$20 per year per child. Much of the food would come from home production, the proportion of the \$20 that must be imported from overseas sources varying, from country to country, from one-fiftieth to one-third, or one-half or even more.

b. The rehabilitation and manning of children's institutions (and services).

This was placed second in importance by the Subcommittee of the General Assembly. The report pointed out that war has destroyed numerous children's institutions and disrupted their services and technical management. Services for the school-age child, the orphan, and the cripple, and services to combat infant mortality and tuberculosis are especially needed. Most of the equipment, the subcommittee thought, could come from domestic sources, but there is a deficit of equipment, medical supplies, clothing, and shoes to be covered by supplies from overseas.

c. Extensive facilities for training the necessary personnel are indispensable, the report of the subcommittee states, if the national programs are to be implemented.

It is hoped that the cooperation of other international agencies may be secured for providing fellowships for personnel needed for child-health and child-welfare services.

The primary emphasis of the Fund, at least in its first period of operation, will be on food for children, but provision for clothing, shoes, cod-liver oil or substitutes, and medical supplies will also receive emphasis.

The Fund will proceed on the basis outlined in the resolution establishing it; namely, that within each country responsibility for meeting these manifold problems rests upon the Federal, central, provincial, municipal, and local authorities as well as upon special agencies and voluntary efforts. Countries applying for assistance will submit proposals to the Fund which will be passed upon by the Executive Board, acting within the framework of principles established by the Economic and Social Council. Information will be required concerning provisions for coordination of the services of all agencies, both official and voluntary, to be utilized in the program, and evidence of need. Under the terms of the resolution countries desiring assistance must make provision for submission of reports on the use of supplies and other assistance, and for equitable and efficient dispensation or distribution of all supplies or other assistance, on the basis of need, without discrimination because of race, creed, nationality status, or political belief. The Fund is not to engage in activity in any country except in consultation with, and with the consent of, the Government concerned. Field staff necessary to cooperate with governments in assuring that the principles established for the operation of the Fund are complied with, will be provided.

A United Nations organization for international relief for children suffering from the war has now been formed. Whether its purposes can be carried out will depend upon the willingness of the countries and peoples of the world to support these efforts which are so important to the welfare of children and the future of the race.

CONFERENCE CALENDAR

Feb. 24-27—American Academy of Pediatrics. Pittsburgh.

Mar. 10—Child Study Association of America. Annual Conference. New York.

Public Housing

(Continued from page 136)

Frequently the residents form clubs for arts and crafts, dramatics, music, in which both children and parents participate. Children from surrounding areas, and their parents, are invited and even urged to participate in the housing-project activities. Children form "junior cities," and other self-governing groups that stimulate and develop good citizenship and leadership. This was demonstrated recently when a boy who had been a leader in a Negro youth group in a project was subsequently elected as moderator of an all-city inter-racial-church youth group.

Problems of housing are simplified for some recipients of public assistance through facilities made available by the Chicago Housing Authority. It is estimated that about 10 percent of the residents in the projects are receiving such assistance, including families receiving Aid to Dependent Children, General Relief, and Old Age Assistance.

An example of mobilizing community services through a housing project occurred at one of the projects several years ago during a whooping-cough epidemic. Mothers came to the authority requesting that something be done to protect children against the epidemic. They were advised to go to the city board of health and request that physicians come to the project to inoculate the children. They were also advised to canvass the mothers so as to have them all bring their children in on the day scheduled for examination. The mothers did such a good job that almost every child in the project was inoculated.

Reprints available on request

●
If the baby on our cover page for February is placed for adoption, his mother and the social agency that helps her plan for his future both have a responsibility to ask him to preserve his identity, in case he ever asks, "Who Am I?" (Photograph by Peter Sekaer.)

(Other credits:

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Page 136, Chicago Housing Authority photograph.

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What Will Your State Do for Children in 1947?

In 44 State capitals the legislature is holding its 1947 session, free for the first time in 7 years from wartime emergency pressure. And from the requests for advice that have come to the Children's Bureau from State officials and from citizens' groups it is evident that these sessions promise important gains for children.

The State legislatures represent a strategic front in improving opportunities for the children of the Nation.

It is from State legislatures that counties and cities and school districts receive the authority to provide services for children and youth—health, education, recreation, social services—and safeguards for youth employment.

The State legislature defines the kind and degree of protection that shall be given by public authorities to children. And it sets up the administrative organization and procedure to see that the rights of children as defined by State law are realized for the individual child.

Let us look at some of the proposals in behalf of children that will come before a number of State legislatures this year.

For example, there are the measures that will benefit children suggested by the Council of State Governments; some of these are new, some carried over from previous years.

One of these measures is for the purpose of giving adopted children more protection. Another is to establish 16 years as the minimum age for employment in factories at any time and for employment of any kind during school hours. A third would require that crippled children's eligibility for receiving services under the Social Security Act would be determined by a medical decision instead of by court action.

The Council suggests also the adoption of State laws that will enable the States to continue to benefit from the National School Lunch Act and that will help them to take full advantage of the Federal Hospital Survey and Construction Act.

Another proposal of the Council is one that calls for the enrichment of white flour and bread, an important measure for the nutrition of children.

Bills to improve educational services for children will undoubtedly be brought up in a number of legislatures. Especially there will be bills to increase State aid to local schools so as to permit, for one thing, the raising of teachers' salaries in an effort to reduce the teacher shortage, which is threatening the education of our children.

The Missouri Children's Code Commission, created by the legislature in 1945, has presented perhaps the most

comprehensive series of proposals for legislation for children that will come before any State legislature this year. The proposals relate to such subjects as maternal and child health; aid to dependent children and child-welfare services under the Social Security Act; the licensing of child-welfare agencies, foster homes, and maternity homes; school attendance and child labor; recreation; the care of exceptional children; State training schools; and services for children requiring adjudication by a court, such as adoption, guardianship, and juvenile-court services.

In several other States commissions or committees planning for children and youth have presented proposals on similar subjects.

Parent-teachers associations, men's and women's organizations, farm and labor groups, veterans' organizations, professional associations, and other groups, have worked with State officials in preparing these proposals for consideration by the legislatures. Now legislative committees are at work, seeking the best possible statement of the public interest in providing for the children of the State.

Are you one of those who will have the satisfaction this year of backing a good child-welfare bill and seeing it passed by the legislature and signed by the Governor?

Katharine F. Lenroot
Chief, Children's Bureau.

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Katharine F. Lenroot, Chief

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THE
CHILD

MARCH 1947



WHY NOT AN OUNCE OF PREVENTION?



Plenty of action at a club. Not a cure for delinquency, but one kind of preventive medicine.

CLARENCE W. MEADOWS

Governor of West Virginia

QUITE FRANKLY, I am not an authority on juvenile delinquency. My thoughts on the subject arise solely from experience gained as a legislator, a prosecuting attorney, an attorney general, a judge, and a Governor. I am unwilling to concede that one may become an authority by the mere study of certain accepted courses dealing with human relations and our social problems. Most certainly all of us who are so vitally interested in this subject keenly feel our individual inadequacy to find the correct solution. Hence the great and impelling necessity to pool all our experience, all our technical training, in order that we may find the right answers for intelligent and effective action at this propitious time.

So highly individualistic is the problem that the great need for more experienced, trained personnel becomes at once apparent, as does the equal need for institutions fully equipped to meet the challenge.

Young lives can never be reoriented in our twentieth century by the medieval method of arrest, conviction, and confinement. Too often, the juvenile offender or delinquent receives the same care as the hardened criminal, and this, instead of salvaging a young life, immediately and too often transforms that youngster into the very kind of citizen we so piously profess to be trying to keep him from being.

Condensed from an address before the National Conference on Prevention and Control of Juvenile Delinquency, Washington, November 20, 1946.

I have seen it, and I have had to deal with it on this plane, and as long as our cities, counties, States, and Federal Government fail to recognize the need for a higher degree of care and guidance for the youngsters of our land who have in some manner transgressed, we can expect no better results in the future than those we have achieved in the past.

Young boys or young girls full of life, unmindful—even as you and I were perhaps somewhat unmindful at one time—of the consequences of their acts, who find themselves suddenly deprived of the freedom they have known . . . and who are forced to pay the penalty for their transgression by merely staring at walls for days without end, can hardly be expected to fall in love with a society which has placed them there. For most of them, there must be another and a much better way.

The cure of any disease is, of course, much to be desired, but of far greater benefit to humanity is the prevention of the disease. And so it is with juvenile delinquency. Important as it is to salvage a youngster who has strayed, it is of much greater importance to society as a whole, and to the future of this Nation, to develop programs or plans which can, in some manner and by some means, effect the prevention of juvenile delinquency. In my honest judgment, it is here that we in government have too long been too neglectful. Now is the time to begin the assumption of our real responsibility.

If juvenile delinquency is to be finally placed among those social problems which are to be considered as solved, the point at which we must begin—and begin in earnest—is that point where the preventive is indicated.

In my State, as well as in each of yours, and in the Federal Government, juvenile delinquency has been widely

discussed. Yes, we recognize this to be a problem. We talk about it. We deplore it. But we end up by doing very little about it. In truth, what has been our greatest effort? I believe the sum total amounts to something like this: We have our juvenile courts and juvenile officers. We have our detention homes, our industrial schools, and places for confinement and training, but beyond that we have devoted little effort except the effort of discussion. We appropriate money. We provide machinery—inadequate as it all is—to cure, but what money have we appropriated—what are we doing governmentally on the preventive side? Very little, I am afraid.

Never before has this problem assumed the proportions that it possesses today. The war has disrupted the life of every citizen and every home, and the strains and stresses of our times have torn the people of our Nation, as well as the people of the world, loose from our strong and stable moorings. So, until the passing of time brings to us a more placid existence, when we shall give higher value to moral and social responsibility, the tide of juvenile offenses will continue to rise unless we meet the problem in a way different from that in which we have been meeting it in the past.

I propose that our governmental units—municipal, State, and Federal—while doing all things possible to cure juvenile delinquency, immediately recognize that our real responsibility begins with prevention rather than with cure. To my mind, the devotion of specialized facilities, highly trained personnel, and liberal appropriations for prevention will pay much higher dividends in good citizenship than anything we can do in the curative field.

Why not start at the beginning? Let us get to the cause of the trouble, rather than begin after the damage has been done.

We in the States and those in the Federal Government have too long dwelt solely upon, and expended our major efforts in, taking care of those who are ill mentally and morally—and that care has not been too good—instead of devoting our resources and our great wealth to the prevention of the very problem we seek to solve. It would be

calling upon your imagination, I am sure—because the living examples of such are so few and far between—to envision what might really be done for the youth of our land, for our future citizens, if we would only devote a small portion of our resources to the carrying out of a program designed to keep juveniles from being delinquent—to give juveniles who have had little opportunity to see other than the seamy side of life, the privilege of enjoying things which make better men and women—the opportunity of lifting themselves up and enjoying life as it should be lived by clean, wholesome youngsters.

Some Children's Bureau publications related to prevention and control of juvenile delinquency

BUILDING THE FUTURE FOR CHILDREN AND YOUTH; next steps proposed by the National Commission on Children in Wartime. Pub. 310. 1945. 59 pp.

CHILDREN IN THE COMMUNITY, the St. Paul experiment in child welfare. Pub. 317. 1946. 182 pp.

CHILDREN IN JAIL. Reprinted from "The Child," April 1943. 5 pp.

COMMUNITY EXPERIMENT IN THE MEASUREMENT OF JUVENILE DELINQUENCY. Reproduced from National Probation Yearbook, 1946. 27 pp.

CONTROLLING JUVENILE DELINQUENCY; a community program. Pub. 301. 1943. 27 pp.

COORDINATING MENTAL-HYGIENE WORK FOR CHILDREN. Reprinted from "The Child," June 1945. 4 pp.

GOALS FOR CHILDREN AND YOUTH IN THE TRANSITION FROM WAR TO PEACE. Adopted by the National Commission on Children in Wartime. Pub. 306. 1944. 12 pp.

GUIDING THE ADOLESCENT. Pub. 225. Revised 1946. 83 pp.

HANDBOOK FOR RECREATION LEADERS. Pub. 231. 1936. 121 pp.

JUVENILE-COURT STANDARDS. Pub. 121. Revised 1937. 10 pp.

JUVENILE-COURT STATISTICS, 1944 and 1945. 12 pp.

MENTAL HYGIENE FOR CHILDREN AND YOUTH; a joint committee statement submitted for consideration to the Committee on Plans for Children and Youth of the National Commission on Children in Wartime. 1945. 15 pp. Mimeographed.

OUR CONCERN—EVERY CHILD; State and community planning for wartime and postwar security of children. Pub. 303. 1944. 84 pp.

STATE AND COMMUNITY PLANNING FOR CHILDREN AND YOUTH; proposals of the National Commission on Children in Wartime. Pub. 312. 1945. 21 pp.

UNDERSTANDING JUVENILE DELINQUENCY. Pub. 300. 1943. 52 pp.

WHITE HOUSE CONFERENCE ON CHILDREN IN A DEMOCRACY—Final Report. Pub. 272. 392 pp.

Detention in jail is a poor way to deal with delinquent youth.



PREVENT DELINQUENCY THROUGH SERVICES FOR *ALL* CHILDREN

TOM C. CLARK

Attorney General of the United States

SINCE THE CAUSES of juvenile delinquency are found in all aspects of our social and economic life, the problem must not be approached on a narrow basis.

Furthermore, these causes have been accentuated by wartime conditions, and by the changes and stresses which aggravate the problem still more as the Nation returns to the days of peace.

We must not only meet the present emergency; we must lay long-range plans for the future.

We must always remember that the same kind of coordinated effort is required for the prevention and control of juvenile delinquency in normal times as is needed in times of special stress such as we experienced during the war and are now experiencing in the days of reconversion.

... each and every community must marshal all its social forces in the war against delinquency. The extent to which a juvenile receives a socialized type of treatment should not depend upon whether he lives in the North, South, East or West, nor upon whether he is a State or Federal offender.

All agencies and people concerned in the prevention or control of juvenile delinquency should pull together, and gird themselves for the common task.

It is of primary importance that we emphasize the strengthening of services that are essential to the well-being of *all* children.

If every community in America strengthened and united its resources for *all* of its children, it would save *many* of them from taking the first stumbling steps toward delinquency.

Those recently returned from the battlefields of freedom learned that no artificial barriers—racial, religious, or

economic—separated men on the fighting front.

Yet some people now act as if good will, understanding, and friendship among men belong only to wartime.

Some individuals, some groups, would turn the hand of one man against another because of difference in race, color, or creed.

Incidentally, 27 percent of our present population are foreign-born, or the children of foreign-born parents or parent.

Indeed, all races and nationalities make up America and contribute to its life.

During the recent war about 109,000 soldiers in American uniform were naturalized, approximately 14,000 of them while on duty overseas. These American soldiers were of 122 different nationalities.

The gap that normally exists between generations is often widened by differences in the customs, traditions, and attitudes of the Old and New Worlds, making the children—especially the native-born children of foreign-born parents—more vulnerable to delinquency.

Delay in community action to mobilize resources to lead children into rich and purposeful living until some are already in trouble is more costly, more difficult, and often too late.

The problem of how best to deal with the juvenile delinquent as an individual to be put back on the road which leads to a happy and useful life, a credit both to society and himself, is common to all communities. It does not differ from jurisdiction to jurisdiction.

Excerpts from an address before the National Conference on Prevention and Control of Juvenile Delinquency, Washington, November 20, 1946.

All children are entitled to happy, wholesome home life. The right kind of home life is vital to the welfare of the child. It is vital also to the welfare of the Nation.

But the home is not complete within itself. It must be fortified and supplemented by the church, the school, and other forces in the community.

After each great crisis in our national life there always seems to be a moral and spiritual letdown. I am happy, therefore, to note that reemphasis of moral and spiritual values is to be given attention.

Society cannot afford to contribute to the delinquency of its children by allowing spiritual guidance and social education to lag behind economic and scientific development.

The church has primary responsibility for spiritual guidance. It can help children distinguish between fundamental values in human conduct and transient ideas as to acceptable and unacceptable behavior. In essence, the church can help to guide youth in the formation of a scale of values in keeping with the principles of democratic living.

The school is strategically placed to reach practically all children. Also it reaches them at an early and impressionable period of life. The school that sees the child's school experience as a part of life itself, as well as preparation for life, can develop healthful habits—mental and physical, proper attitudes and interests and a sense of civic responsibility.

The school is in a position to recognize attitudes and behavior that may be the forerunners of delinquency. An all-round good school helps to prevent delinquency.

Everyone has need for fun, relaxation and release, and self-expression. Recreation can play an important role in the conservation of youth as it meets the needs of millions of our young people.

As services become more nearly adequate for the millions of our youth, offenders and delinquents will become fewer.

Passing from the general requirement of meeting the needs of all children, we know that specialized services are necessary to meet the special needs of certain children.

For example, some children require special protection of the community. They are the physically and mentally handicapped children, the boys and girls in employment, the children of working mothers, and the children who live in congested areas, or whose families are in economic need.

In addition, some community conditions are destructive to the welfare of children. The elimination, or control, of such harmful or potentially harmful influences that lead children into delinquency is a public responsibility.

The delinquent child or youth needs the basic services and resources that are essential for all children. He needs the protections that are necessary for the child in danger of becoming delinquent. He needs skillful handling of his own particular problems.

He needs help from the home, the school, the church, the youth-serving organizations, the social agencies, the law-enforcement bodies, and all the other forces in the community that can play any part in his training, readjusting, and re-creating.

This multiple approach to the problem of juvenile delinquency, its prevention and control, involves a community of social forces and a concentrated and coordinated effort on the part of all in building a well-rounded and evenly developed program.

We can meet and mobilize public opinion concerning the problem with which we are confronted—we can make specific recommendations for action; can carry out some of these recommendations. But the essential responsibility must rest with the local communities. It is for them to utilize the reports and the results of this conference. It is for them to take these reports and to translate them into coordinated community effort.

TOOLS FOR ACTION TO PREVENT AND CONTROL DELINQUENCY

AT THE CLOSE of the National Conference on Prevention and Control of Juvenile Delinquency, held November 20-22, 1946, at Washington, 15 discussion panels presented their final reports, on various phases of the problem, to the conference in plenary session. Summaries of these reports are now available in a bulletin, "Recommendations for Action," published recently by the Department of Justice, (Washington, 1947, 136 pp.). The full reports will be made available as soon as they can be printed.

Each of the panel reports, says the bulletin, is a "tool for action," primarily at the community level. Each recommendation has been specifically allocated to individuals or groups, who, in the opinion of the conference, have the primary responsibility in the community for initiating the particular action and carrying it through.

Planning for prevention of delinquency, says the report on community coordination, should be an integral part of the community's programs of health, recreation, housing, and schools; a part of its religious, economic and business life; as well as of its programs for courts and police, and its protective

services for children with definite behavior problems.

The report on institutional treatment of delinquent juveniles lists the phases of treatment that are designed to make such institutions places for the reeducation and retraining of the individual children committed to their care.

The "Standard Juvenile Court Act," drafted by the National Probation Association and revised in 1943, is endorsed by the report of the panel on juvenile-court laws, administration, and detention facilities. The panel also suggests some amendments to the standard act.

Well-qualified personnel needed

The section of this panel's report that is devoted to administration of juvenile courts calls attention to the need for well-qualified personnel and for procedures and facilities suitable for dealing with the problems of children.

States and communities are in great need of field-consultant service concerning detention facilities, and this service might well be provided by national agencies.

The report on the role of the police in juvenile delinquency sets forth the

Here it is Saturday, and no place to go. Boys as bored as these may seek the kind of excitement that leads to trouble.



views of the majority of the panel, but says that minority opinions were voiced as to certain parts of the report and as to certain of the recommendations. The report develops the point of view that primary consideration on the part of all agencies dealing with the control and prevention of juvenile delinquency is the protection of society, with the needs and privileges of the individual being given secondary, but very important consideration.

Recreation is no cure-all for juvenile delinquency, says the report on recreation for youth. But it may make an important contribution to the social treatment of delinquent juveniles, and it is one of the effective instruments for the prevention of delinquency. Recreation serves best as a preventive force when opportunities for wholesome recreation are provided for all youth everywhere, according to the report.

Individual citizen responsible

"This means YOU." Thus the report on housing and community development addresses the individual citizen in making clear that the responsibility for bringing about a better environment for American youth belongs to every one of us. The report also recommends specific action by private builders, banks, labor leaders, religious leaders, legislative bodies, mayors, health departments, housing authorities, and other agencies.

The report on youth participation itself is an example of youth participation. Four young persons (the oldest 24 and the youngest 17), assisted in preparing the report, and there was no thought of considering them as a group apart from the older people. Their ideas and suggestions were accepted or modified after discussion in exactly the same way as those of their elders.

In directing its attention to the potentialities and responsibilities of all citizens in accomplishing the objectives of the conference, the report on citizen participation addresses its recommendations not only to individual citizens but also to youth-serving and other community agencies and to community-planning groups.

The bases for socialized behavior are laid in childhood, says the report on mental-health and child-guidance clinics. All who deal with children, the re-

port goes on to say, have the obligation to acquaint themselves with the fundamental emotional and mental needs of childhood and to realize how the frustrations or satisfactions of these needs are reflected immediately or later in behavior. Knowledge of the part that the fundamental needs play in the development of the young individual really means acquaintance with mental-hygiene principles. Understanding and proper application of these principles, the panel believes, will go far in reducing juvenile delinquency.

How social services can help delinquent children and their parents is suggested in the report on case-work and group-work services. The contribution that case-work and group-work programs can make to the solution of the problem of juvenile delinquency is of necessity closely related to the broad social programs that are designed to assure the economic, social, and physical well-being of each person in the Nation. Case workers and group workers share with other citizens the responsibility to work for the establishment of such programs.

The report on church responsibilities opens with a positive assertion of the importance of religion in the prevention and control of juvenile delinquency. It states that religion (and that means church and synagogue) is not merely an adjunct or ally of other social forces combating delinquency, but is fundamental to the best that they have to offer. The recommendations urge that priests, ministers, and rabbis cooperate closely with the police, probation officers, judges, social workers, school officials, mental-hygiene clinics, and other agencies dealing with children who have behavior problems. They urge also that all religious groups encourage their congregations to respect people with different cultural and religious backgrounds.

Assisted by all other forces of the community, the school can and should attack the problems of juvenile delinquency, according to the report on school and teacher responsibilities. The school, because of its constant and intimate contact with all the children, occupies a strategic position in attacking this problem, the panel says. Although the larger part of the attention of the

school should be directed toward developing a complete school program that will make the pupils less likely to form undesirable patterns of behavior, the report goes on, the school must also accept responsibility for dealing with such behavior when it occurs.

To help families

Specific suggestions to parents are made by the panel report on home responsibility to help them understand the tensions that cause antisocial behavior in their children. The recommendations place emphasis on the personal adjustment and positive attitudes that help make a "good" home.

Delinquency statistics, according to the report on that subject, may be classified into three groups: (1) Data on the numbers and characteristics of children dealt with as delinquent; (2) data on the character of and circumstances surrounding delinquent acts; (3) data on socioeconomic and psychological factors involved in delinquency.

A realistic approach to the problems of juvenile delinquency in rural areas needs to take cognizance of the distinctive patterns of rural life, says the report on rural aspects of juvenile delinquency. Most obvious of these is that rural people live less close together than urban people; they rely more on personal contacts; the maturing children have a more responsible part in making the family living; there is less formal organization and more informal activity; and behavior is determined more by local custom and less by law than in urban communities. There is need for capitalizing on the conditions in rural life that tend to hold juvenile delinquency to a minimum, and to develop programs for dealing constructively with such delinquency as does occur. Though it is clear that juvenile delinquency in rural areas, as elsewhere, can be effectively prevented and controlled only by the community itself, local leaders will want to profit from the experiences of other communities and from the assistance they can obtain from Federal and State agencies.

An additional panel, on press, radio, and motion pictures, also met during the conference, and plans to conduct a postconference study of the other reports and then submit its report.

WARTIME INFANT AND MATERNAL MORTALITY RATES SHOW CONTINUED IMPROVEMENT

a summary for 1943 and 1944

DESPITE wartime conditions, and the withdrawal of a very large number of physicians from civilian practice to serve in the armed forces, a steady improvement took place throughout the war in the Nation's maternal and infant mortality rates.

From 45.3 per 1,000 live births in 1941, the death rate among infants dropped year by year until, in 1945, it reached the lowest level, 38.3, ever achieved since mortality records were first kept. From 31.7 per 10,000 live births in 1941, the death rate among mothers during childbearing, likewise, dropped to its lowest—20.7—in 1945. Provisional figures for the first 9 months of 1946 indicate that the trend toward lower infant and maternal mortality is continuing.

During the latter half of this time—beginning with April 1943—the Emergency Maternity and Infant Care program was in operation. Under this program medical, nursing, and hospital services for maternity care were made available to more than 962,000 servicemen's wives through the end of 1945 and, during the same period, to almost 132,000 infants during their first year of life. The effect of this program on maternity and infant mortality rates cannot be definitely stated.

This steady reduction in death rates for mothers and infants occurred against a fluctuating birth rate. Climbing from 18.9 births per 1,000 population in 1941, the birth rate reached its wartime peak in 1943 with 21.5. In 1944 it dropped to 20.2. In 1945 it dropped again to 19.6. (Preliminary estimates made by the Bureau of the Census predict a sizable upswing in 1946, when it is expected the number

of births will exceed any in the history of the country.)

The following analysis of these vital statistics for 1943 and 1944 is a summary of a more complete presentation by Dr. George Wolff, which will appear as a separate monograph under the title, "Maternal and Infant Mortality in 1944." Readers interested in receiving this publication are invited to address requests for a free copy to the U. S. Children's Bureau, Washington 25.

Data on the years 1933 to 1943 are given in "Ten Years of Progress in Reducing Maternal and Infant Mortality," by Dr. Marjorie Gooch, a reprint from *The Child*, November 1945, copies of which are also available.

Births

1944 marked the turning point in the wartime increase that took place in births. The number registered for that year, 2,794,800, was 5 percent lower than the 2,934,860 registered in 1943, the year of the greatest number of live births during the war. Of the 1944 total, 1,435,301 were boys; 1,359,499 were girls. That is, for every 100 female infants, there were 106 male infants.

Based on the estimated midyear population, including armed forces overseas, the birth rate per 1,000 population was 20.2 in 1944, compared with 21.5 in 1943.

Complete registration of births has not yet been achieved in our country. Although, since 1933, the entire continental United States has been included in the birth-registration area, here and there births still take place which go unrecorded. From a test made in 1939-40 by the Bureau of the Census, some 200,000 births occurring each year appear to be unregistered. Registration

of white births is estimated as 94 percent complete; of nonwhite births, 82 percent complete.

Birth rates for the United States from 1933 to 1944:

Year	Rate	Year	Rate
1933	16.6	1939	17.3
1934	17.2	1940	17.9
1935	16.9	1941	18.9
1936	16.7	1942	20.9
1937	17.1	1943	21.5
1938	17.6	1944	20.2

The State with the highest birth rate in 1944 was New Mexico, where 32.1 births per 1,000 population were registered. South Carolina was next, with 29.0; and Mississippi third, with 28.9. New York had the lowest rate (18.6) for any State, and was followed by New Jersey (18.8) and Illinois (18.9). In general, Southern States and some of the Mountain States (New Mexico, Utah, Idaho) have rates above the United States average, while in the more industrialized States of the Northeast the rates usually fall below the national average.

Of the 2,794,800 registered live births in 1944, 2,454,700—or 87.8 percent—were white; 324,183—or 11.6 percent—were Negro; 15,917—or less than 1 percent—were of other nonwhite races. Distribution in 1943 was very similar.

The birth rate for the nonwhite population, as in preceding years, was higher than for the white population. In 1944 the nonwhite rate was 23.7 per 1,000 population, against the white, 19.8. Breaking down the figure for the nonwhite group brings out some interesting racial comparisons. The lowest birth rate for 1944 occurred among the Chinese, 16.3 per 1,000 population. For persons of Japanese origin, the rate was 23.0. For Negroes, who make up all but 1 percent of the whole nonwhite group, the rate was 23.7. Indians had the highest rate, with 28.5 registered births per 1,000 Indian population. This high birth rate among Indians, however, must be matched against their death rate, which continues higher than for the Negro or white population.

Maternal Mortality

1944 stands out significantly as the year with the lowest maternal mortality rate recorded for the United States

from the beginning of birth registration in 1915 up to that time. The rate was 22.8 per 10,000 live births, as compared with 24.5 in 1943, and 25.9 in 1942.

In actual numbers 6,369 deaths from puerperal causes occurred in 1944. This was 11.5 percent fewer than the deaths in 1943, and 12.4 percent fewer than in 1942.

A comparison of the rates in 1942 and 1944, when the total number of live births was almost the same, shows that nearly 900 more mothers would have died in 1944 if the 1942 rate had prevailed.

By States—Twenty-eight States and the District of Columbia in 1944 had rates better than the 22.8 average for the country; 20 had poorer rates. Records of the various States point up the still further gains that could be made if all States had records as favorable as the most advanced States.

Wyoming took first place as the State with the lowest maternal mortality rate. With 5.635 births, five mothers lost their lives. Wyoming's rate, therefore, was 8.9 per 10,000 live births. If all States had had the same low rate, the loss of life for the Nation as a whole would have been half as great as it actually was. However, the low rate in Wyoming this year might be partly due to chance.

Wyoming was followed by Utah with 13.6, and Minnesota with 13.7. The States with the highest maternal mortality rates were New Mexico (39.8),

Mississippi (38.5), and South Carolina (37.5).

By race—Risks of childbearing, the 1944 record shows, continue to bear unevenly on white and nonwhite mothers. For the whole country, the death rate for white mothers was 18.9 per 10,000 live births; for nonwhite mothers, it was 50.6—almost three times as high. It is not surprising, then, to find the States with sizable nonwhite populations showing the poorest record, and these figures point directly to groups most urgently in need of better care. While there was a decrease of 10 percent between 1943 and 1944 in mortality rates for white mothers, the decrease for nonwhite mothers was less than 1 percent. As one authority recently said: "Obstetric care has undergone an evolution in this generation, but the Negro has not participated fully in the benefits of modern obstetrics. It is not possible to have two systems of maternal welfare; there must be one all-inclusive health program."¹

By age—If maternal mortality can serve as a criterion, the age most favorable for having children is 20 through 24. Both in 1943 and 1944, the mortality rates for this age group were the lowest. The rate in 1943 was 15.8; in 1944, 14.2. The youngest mothers, 10 through 14, who have hardly reached physical maturity, have a very high death rate from puerperal causes—99.0

in 1943, 42.1 in 1944. Older mothers also have a rate considerably worse than average. For mothers 35 through 39 the rates were 51.0 in 1943 and 45.4 in 1944; for those 40 and over they were 76.6 in 1943 and 69.8 in 1944. It is encouraging that the decline in maternal mortality rates applies to all age groups.

By cause—Of the 6,369 maternal deaths in 1944, 2,276 or 36 percent were caused by puerperal infection (septicemia, phlebitis, thrombophlebitis, pyelitis, etc.); 1,607, or 25 percent, by all kinds of puerperal toxemia; and 1,897, or 30 percent, by hemorrhages of pregnancy and childbirth, including trauma and shock.

These three main causes taken together accounted for 91 percent of all maternal deaths in both 1944 and 1943. In general, the rate of decrease in each of the three causes tends, over a period of years, to be about the same.²

An analysis of maternal deaths according to termination of gestation brings other facts to light. Two-thirds of deaths following abortion (gestation less than 28 weeks) both in 1943 and 1944 were caused by infection. A majority of the deaths occurring before delivery were caused by toxemia. The principal causes of death in 1944 during or after delivery were: (1) Hemorrhage, trauma, and shock; (2) infection; and (3) toxemia. As might be

¹ Williams, Philip F.: Maternal Welfare and the Negro. *Journal of American Medical Association*, 132: 611-614 (Nov. 16, 1946).

² Gouch, Marjorie: Ten Years of Progress in Reducing Maternal and Infant Mortality. *The Child*, 10: 77-83 (November 1945).

MATERNAL MORTALITY, UNITED STATES AND EACH STATE, 1944 AND 1943¹

Area	1944		1943		Area	1944		1942	
	Number of maternal deaths	Rate (deaths per 10,000 live births)	Number of maternal deaths	Rate (deaths per 10,000 live births)		Number of maternal deaths	Rate (deaths per 10,000 live births)	Number of maternal deaths	Rate (deaths per 10,000 live births)
United States	6,369	22.8	7,197	24.5	Montana	16	14.6	20	17.5
Alabama	278	37.4	290	33.5	Nebraska	43	17.5	42	16.8
Arizona	42	20.5	38	26.6	Nevada	7	23.1	6	19.8
Arkansas	114	27.6	168	39.4	New Hampshire	24	28.1	25	26.7
California	304	17.0	357	20.5	New Jersey	120	15.7	161	19.4
Colorado	59	24.7	63	25.9	New Mexico	42	39.8	71	46.7
Connecticut	52	15.2	63	16.2	New York	425	18.5	521	21.0
Delaware	9	15.0	15	24.1	North Carolina	266	29.4	306	32.4
District of Columbia	33	20.9	35	21.8	North Dakota	24	17.7	39	29.1
Florida	161	33.3	173	37.0	Ohio	257	19.2	324	22.5
Georgia	279	36.5	307	39.2	Oklahoma	121	23.8	122	25.1
Idaho	30	24.5	29	23.4	Oregon	43	17.8	38	14.9
Illinois	284	17.9	320	20.5	Pennsylvania	454	25.5	493	24.7
Indiana	131	19.8	149	24.9	Rhode Island	25	38.2	33	22.5
Iowa	83	17.8	80	16.8	South Carolina	135	37.5	240	44.3
Kansas	64	18.3	77	21.4	South Dakota	23	18.0	20	15.6
Kentucky	159	24.8	163	24.9	Tennessee	191	28.0	204	29.1
Louisiana	307	33.9	359	32.1	Texas	422	25.4	420	25.5
Maine	40	22.5	42	22.2	Utah	12	13.6	27	15.7
Maryland	82	18.7	75	17.9	Vermont	13	19.1	16	21.9
Massachusetts	140	17.9	183	20.1	Virginia	183	26.5	210	29.1
Michigan	193	22.6	226	28.0	Washington	70	15.7	72	16.2
Minnesota	77	13.7	84	14.4	West Virginia	21	30.0	126	29.1
Mississippi	219	38.5	236	39.4	Wisconsin	109	17.7	127	19.7
Missouri	152	22.4	183	25.5	Wyoming	5	8.9	9	15.5

¹ Tabulations are by place of residence of deceased.

expected, the great majority (four-fifths) of the deaths during ectopic gestation were due, in both years, to hemorrhages.

Infant Mortality

Just as with maternal mortality, 1944 marked the lowest point in infant mortality rates between 1915 and that year. For 1944 the rate as usually computed was 39.8; for 1943, 40.4; for 1942, 40.4. (Adjusted for the changing number of births, these rates were: 39.4 in 1944; 40.7 in 1943; and 41.2 in 1942.) In actual numbers 111,127 infants died in 1944, 118,484 in 1943, and 113,492 in 1942.

Risk of death, it is well known, is greater for male than for female infants, and the record for 1944 further confirms this. Of the 111,127 infants who died, 63,264 were male, and 47,863 were female. Even when infant deaths are measured against the number of births in each sex, the rate is distinctly higher among boys than girls.

By States.—National averages obscure the advances some States have made in reducing their infant mortality rates. For white and nonwhite groups combined, 25 States in 1944 did better than the country as a whole; 23 States and the District of Columbia did less well.

Oregon had the best record, with 30.5 infant deaths per 1,000 live births. Connecticut came next, with 30.7; and Minnesota third, with 31.3. At the bottom of the list stood New Mexico

(89.1); Arizona (68.8); and South Carolina (54.9).

States with predominantly white population tend to have lower rates. But even in States with large nonwhite population the white rate is frequently better than the average for the country. This is true, for instance, in the District of Columbia and in Maryland, where the white rates are below the national average while the nonwhite are well above it.

By race.—Differences in mortality rates between white and nonwhite infants point up in still another way possible gains to be made in the future. Mortality among white infants in 1944 averaged for the country 36.9 for every 1,000 live births. Among nonwhite infants, it was 60.3.

While greater gains were made between 1943 and 1944 in the reduction of maternal mortality rates among white mothers than among nonwhite, the reduction in the infant mortality rate was 1.6 percent for white infants and double that (3.5 percent) for nonwhite infants.

Causes of death.—In 1944, as in 1943, the five leading causes of infant mortality were: (1) Premature birth; (2) pneumonia and influenza; (3) congenital malformations; (4) injury at birth; (5) diarrhea, enteritis, etc. Nearly three-quarters of all infant deaths in 1944 were due to these. Close to one-third were deaths of premature infants.

Acute infectious diseases of childhood, such as measles, scarlet fever,

whooping cough, and diphtheria, and the more chronic infections, such as dysentery, tuberculosis, and syphilis, continue to shrink in importance.

Significant differences between white and nonwhite infant mortality figures show up here. Although the absolute numbers are small when compared with the leading causes of death, death from syphilis is 13 times and from tuberculosis 5 times as frequent among nonwhite as among white infants. Death from congenital malformations is one of the few groups in which nonwhites show a definitely lower rate (about half in 1944 and 1943) than do whites.

By age at death.—Infant mortality continues highest on the first day of life, declining gradually from day to day, from week to week, and from month to month. Of the 111,127 infant deaths in 1944, 29 percent occurred on the first day (same as in 1943); 33 percent after the first day but before the end of the first month (32 percent in 1943). The remainder occurred during the following 11 months of life.

Neonatal mortality (under 1 month) has not decreased to the same degree as the mortality rate in succeeding months, with the result that the proportion of neonatal deaths to all infant deaths has been increasing during recent years. If infant mortality is to be decreased, there must be more and more concentration on the neonatal period.

Another area needing increased attention is the problem of stillbirths. For

(Continued on page 158)

INFANT MORTALITY: UNITED STATES AND EACH STATE, 1944 AND 1943¹

Area	1944		1943		Area	1944		1943	
	Number of infant deaths ²	Rate (deaths per 1,000 live births)	Number of infant deaths ²	Rate (deaths per 1,000 live births)		Number of infant deaths ²	Rate (deaths per 1,000 live births)	Number of infant deaths ²	Rate (deaths per 1,000 live births)
United States	111,127	39.8	118,484	40.4	Montana	345	36.1	442	38.7
Alabama	3,380	45.5	3,477	—	Nevada	810	33.0	880	35.5
Arizona	979	68.8	1,097	41.8	New Hampshire	152	30.2	158	32.2
Arkansas	1,433	34.7	1,594	36.7	New Jersey	322	37.7	432	46.1
California	6,177	34.5	5,999	34.4	New Mexico	2,593	34.0	2,746	33.7
Colorado	1,183	49.4	1,228	30.6	New York	1,389	30.1	1,394	31.6
Connecticut	1,054	30.7	1,162	29.8	North Carolina	7,535	32.8	8,125	32.7
Delaware	292	38.7	291	46.7	North Dakota	4,115	45.4	4,416	46.7
District of Columbia	706	44.8	765	47.6	Ohio	479	35.4	468	34.9
Florida	2,292	35.5	2,181	47.6	Oklahoma	5,147	38.5	5,610	39.1
Georgia	3,407	44.5	3,636	46.7	Oregon	1,923	31.2	2,079	42.3
Idaho	416	34.0	396	32.0	Pennsylvania	7,736	30.5	7,63	30.0
Illinois	4,602	32.4	5,184	32.0	Rhode Island	7,136	40.0	7,551	37.9
Indiana	2,462	34.5	2,960	33.3	South Carolina	486	45.3	638	43.5
Iowa	1,540	32.1	1,618	29.6	South Dakota	2,828	32.0	2,885	33.1
Kansas	1,163	33.3	1,212	23.6	Tennessee	3,106	45.5	3,113	44.8
Kentucky	2,997	46.7	3,280	50.9	Texas	8,354	50.4	8,451	51.4
Louisiana	2,824	46.3	2,773	46.7	Utah	548	33.9	539	31.4
Maine	829	46.7	972	51.3	Vermont	277	40.6	285	39.0
Maryland	1,821	41.5	2,037	43.0	Virginia	3,261	47.1	3,395	47.1
Massachusetts	2,585	33.1	2,939	34.2	Washington	1,506	35.8	1,530	34.8
Michigan	3,345	37.9	3,813	34.3	West Virginia	2,149	47.0	2,261	43.0
Minnesota	1,756	31.3	1,869	30.9	Wisconsin	1,972	32.0	2,257	35.0
Mississippi	2,513	44.1	2,800	46.8	Wyoming	232	41.2	216	37.1
Missouri	2,558	37.6	2,918	40.3					

¹ Tabulations are by place of residence.

² Deaths under 1 year, exclusive of stillbirths

FOR HEALTHIER SCHOOL CHILDREN

TO WHAT EXTENT have the services designed to improve the health of school children in this country done so? Certainly there have been striking decreases in the morbidity and mortality of the diseases that commonly attack children. Smallpox, measles, diphtheria, impetigo, scabies, pediculosis—these no longer constitute major problems. There is, however, a serious question as to whether the activities carried on in the school are largely responsible for these advances. One cannot gainsay the many reports that have indicated success in correcting physical defects. A number of children have been helped to a better physical condition. And although some of this individual improvement might have come about anyway, through the influence of parents for example, it seems clear that the school often played a significant role. On the other hand, there is little evidence that a generation more aware of its health needs has developed, or that the health instruction that school children are given leads to desirable health practices in adulthood.

Despite these advances, the health status of our school children still leaves much to be desired. The examinations of draftees in World War II have often been misinterpreted. However, these results show that although many defects had been corrected, there were many correctible physical defects known to school authorities which had gone uncorrected. Current activity in both local and national legislative bodies, however, shows that just as in the last postwar period our citizens are concerned with problems of the health of children. They are demanding that the failures of the past shall not recur. They are planning to supply funds for expanded services. How shall we, as experts, advise them?

We shall here discuss only one aspect of the problem, that usually known as the health-service program, or, as we prefer to put it, the activities of doctors, dentists, and nurses which are

By LEONA BAUMGARTNER, M. D., Director, Bureau of Child Hygiene, New York City Health Department. MYRON E. WEGMAN, M. D., Department of Pediatrics, School of Medicine, Louisiana State University, New Orleans, and GEORGE WHEATLEY, M. D., Vice President, Health and Welfare, Metropolitan Life Insurance Company, New York. Given November 14, 1946, at the annual meeting of the American Public Health Association, at Cleveland.

concerned with the school population. This does not mean we do not have an essential interest in all other phases of the program. All workers in this vineyard have overlapping interests, and mutual planning is essential. From our experience, however, it would be less than realistic to fail to point out that all too often doctors are told what they *should* do by people who do not know what a doctor *can* do. We are therefore confining ourselves to a discussion of direct health services to children.

We believe medical and dental services for school children are still very far from achieving their goals for at least five specific reasons.

1. Our programs have failed to state that their objective is to secure the best services modern medicine has to offer for all children of school age.

2. The public, including parents, taxpayers, and public officials, has not yet become sufficiently aware of the need for giving adequate financial support to develop a satisfactory program.

3. Although there have been important developments in basic medical research, the methods of applying the results of such research to school populations lag far behind in their development.

4. Despite a marked improvement in

cooperation among the many groups concerned, we still lack a unified philosophy and set of objectives. Too often well-meaning educators, health officers, physicians, dentists, nurses, and parents spend too much time either talking endlessly on how to cooperate, correlate, integrate, or whatever the acceptable verb may momentarily be. Sometimes departments of education and health actually compete with each other for authority and credit. And in the meantime, graduating class after graduating class leaves the school in poor physical condition because of inadequate medical and dental attention.

5. There are too few persons sufficiently well trained to give adequate service to children. This would seem to be, as the Advisory Committees of the Children's Bureau recently pointed out, the most pressing problem of the immediate future.

We can and must take a new view. To secure more funds, more doctors, more dentists and more nurses just to do the same old job is not enough. It is clear that funds must be allotted, even at the expense of delaying service to some children now in school, to train personnel and to establish continuing research projects, both for fundamental medical research and for developing methods of applying research results to school children. We believe the public will make up its mind to support more adequate programs when it sees more clearly what we are driving at and is sure that we can get results. All this points not only to the need for education and propaganda, but also to the need for a more concrete program. We have, therefore, endeavored to state in more exact terms *what* we believe a good medical and dental service to school children must be. We have divided the discussion into two parts: (A) Establishment of an adequate case-finding program; and (B) maintenance of an adequate follow-up program—that is, doing something about what we discover through the case-finding program.

Adequate case finding comes first

We have used the term case-finding, which is commonly used in connection with controlling specific diseases in the general population, because it emphasizes methods of finding the child who is in need of medical care. An adequate case-finding program for school children demands chiefly: (1) Periodic medical and dental examinations, (2) mass testing procedures, and (3) continuous observations by teachers. There are also other requirements in connection with the examination. One is accessory consultation service by specialists—pediatricians, ophthalmologists, otologists, orthopedists, psychiatrists, psychologists, orthodontists, and so forth. Another is access to diagnostic laboratory service, such as roentgenography, electrocardiography, and serological or hemotological studies. And still another is determination of each child's immunization status, with regard to diphtheria, smallpox, and whooping cough, as well as tetanus and typhoid when indicated.

Periodic examinations

Let us first discuss periodic medical and dental examinations given by persons trained to know medical and dental problems in children.

Medical examinations.—It is clear that thorough examinations by a physician at regular intervals are essential if the health status of the child is to be

improved. But how often should these examinations be given? There is pressure from many school authorities for annual examinations. But if these are not thorough and are not accompanied by adequate follow-up programs, they lead to little except a sense of false security for the school and the public. Actually the usual annual-examination program should be exposed as a hoax. Expenditure of public funds for examinations of school children by a physician is justified only if the examinations benefit the child.

The main argument for these examinations is that they discover physical ailments, although this cannot usually be done by means of a hasty examination. Two other arguments are usually advanced: (1) That the examinations protect the school personnel by putting on file a doctor's statement concerning a child's fitness for physical activities; (2) that it inculcates in the child the habit of having an annual physical examination, which he will continue throughout life.

But it is uncertain how much protection the doctor's certificate actually is in case of a lawsuit. And a great many reports of annual examinations are of no value in court, since they do not represent current conditions. Also, it can be easily proved that the examination was so superficially made that the report is of less value than the paper on which it is written.

As to forming a habit of having an-

annual examinations, we have no evidence that pupils form such a habit. And certainly it is not good practice to teach that superficial examinations, with the child's clothes on or only partially removed—examinations made at the rate of one a minute—are the medical examinations one should expect from a physician.

Medical examination of a school child is of value when it discovers any ailment the child has, when it leads to the treatment of such ailment, and when it guides the parent in the further care of the child, so that he may achieve his optimal growth and development. Few school systems can now afford both the routine annual examination and the follow-up program. It is generally agreed that the *optimal* management of the school child and adolescent involves a thorough examination annually. But if we cannot now reach this goal, let us examine carefully to see whether we are using what medical service we have as effectively as we can. Let us press toward a goal of four examinations in the course of the child's elementary- and secondary-school career, the goal agreed on by the National Conference for Cooperation in Health Education. It has been clearly demonstrated that when this goal cannot be reached (as is usual), it is more productive to examine the children that have been selected through the daily observation of the teacher than to examine whole classes of children.

Dental examinations.—The problem of giving dental service to children in a public program is always made more difficult by the huge load of work that needs to be done, and, as a rule, with pitifully inadequate facilities. We know that good dental health requires annual—and, much better, semiannual—detailed, careful examination by a dentist, and correction of any lesions found. Inspections by physicians or teachers are no substitute for this. Unquestionably every school should teach children that they need semiannual dental examination and correction, and should support its teaching by making arrangements with dentists and referring children to them.

As to treatment services within the school system, just how to use whatever such services are available has not been answered definitely. Complete cover-

Daily observation by a teacher trained in dealing with health problems helps to find the child who needs medical care.



age of the lower grades has its advocates against those who propose a selective policy of following a limited group throughout its school career. Here, again, the need for public-health research in dentistry is vital. It seems clear, however, that since dental caries is prevalent throughout the United States the time of school dentists should be spent in filling cavities and in protecting the teeth and oral tissues, instead of merely searching for caries, which is obviously present most of the time.

Mass testing

The second essential for an adequate case-finding program is a procedure for detecting special conditions, such as tuberculosis, parasitic infections, and nutritional status. For this purpose it will be necessary to have available facilities for mass testing of the school children.

Observation by teachers

We have listed continuous observation by teachers as the third chief need for case finding. In recent years we have found great emphasis laid on this activity. But when teachers are insufficiently trained in dealing with health problems it may be only a formality. The current revisions of syllabi on health that are used in teacher-training institutions have recognized this fact, but even now the training in this field is hardly adequate. Much more attention must be given to organized, effective training of teachers in observation of pupils' health.

Follow-up programs must be strengthened

We have long known that case finding without adequate follow-up is extravagant and almost useless. The lack of good follow-up has been the greatest weakness of health service for school children in America. In many schools the objective of the health program—if it has an objective—would seem to be completion of statistics on the number of defects found, or attainment of 100-percent examination of children annually or biennially. If such things are the objectives, little wonder so many children leave school with unimproved health. Let us see what is needed if we are to concentrate

on getting something done about what is found.

First, there must be an effective interpretation of the findings and recommendations to parents, children, teachers, administrators, and others concerned with the health and welfare of the child. Due regard should be given to safeguarding so-called confidential information, but such safeguards should not militate against the child's obtaining what he needs. Interpretations of this kind are, for the most part, inadequately done. Too little time is allotted and personnel are often too poorly trained to give or receive such information successfully. Doctors are usually engaged to "make examinations" and are often given little or no time to tell parents or teachers what needs to be done. Still, physicians and teachers have much to learn in this area. Nurses and social workers are usually better prepared to carry out this part of the program.

sources for medical and dental care and psychological guidance, we shall not have an effective health service for school children. This does not mean we are advocating that schools should establish complete treatment facilities. Far from it. They have their own educational functions to perform. Treatment facilities are needed by all in the community. School and health authorities must, however, find ways of making the facilities that exist in the community readily accessible to school children and find ways of stimulating the community to furnish enough so that all may be cared for. The care given in the offices of private physicians and dentists, and paid for by parents, must be included when over-all facilities are surveyed. Let us face honestly the fact that we have for years discovered thousands of school children who need further medical care and whose parents will not or cannot supply it. And we have failed to plan how *all*

Many ills can be prevented, and the cost of preventing them is usually less than the cost of care after the damage is done.



Secondly, school children must have access to continuing professional services so that their medical and dental needs may be cared for. Although many communities have serious lacks, in general the United States has the richest medical resources in the world. But until such time as we find a way to lead our school children to proper re-

children will get the care they need.

These curative services must include laboratory diagnostic services, facilities for immunization against the preventable communicable diseases, and facilities for the correction of abnormalities of vision and hearing and for the treatment of parasitic infections; tuberculosis, psychiatric problems, and other



Instead of an annual routine examination, let us press toward a goal of four thorough ones during the child's elementary- and secondary-school career, the goal that has been agreed on by the National Conference for Cooperation in Health Education.

conditions that are discovered through case-finding procedures.

Thirdly, actual follow-up work with school children is best guided by a public-health nurse. Her day-to-day work in schools and homes brings results. Every school child needs her services. But careful planning is needed to avoid duplication in the community's nursing services. The principle of generalized nursing service has been established to avoid just this duplication. Certainly where more than one nurse visits a home it is essential that each nurse knows what the other is doing.

At this point, a word should be said about the need for guidance of the nurse so that she will know which recommendations are urgent and which are not. For a concrete example: The great vogue for tonsillectomy, fortunately weakening but still very much alive, has wasted countless hours for nurses who have energetically tried to persuade mothers that a tonsillectomy and adenoidectomy was necessary, when the indications were of the scantiest. Tonsillectomy is such a nice specific thing to do, of course, and so much of the advice

given in other conditions is rather intangible, that both school physicians and nurses seized on the procedure with delight. Right now, a great part of the nurses' follow-up work has to do with taking out tonsils. Let the school physicians be honest and realistic. Let them indicate definitely for the nurses' guidance which of the cases—very few to be sure—really require "T & A." Then the nurse can clear her follow-up file and turn her attention to more important things.

And let us not forget that the child who is sick at home or in the hospital must also have good nursing care.

Finally, the child who needs care in a convalescent home or a residential school, or psychiatric care, or social services should be given access to these.

The program for school children just outlined may sound fantastic, particularly for the rural school or the school system that employs a doctor one week out of the year for a preschool roundup. But service of this kind is essential if school children are to benefit from what American medicine has to offer them. Perhaps if we were to concentrate on

this type of program as our objective we would no longer find taxpayers, parents, school superintendents, and doctors content to have examinations done at the rate of 15 an hour. We might even find the taxpayer interested in supporting something he could be more sure would bring results than today's program.

Certainly many of the ills of adulthood have their beginning in childhood, and certainly many of them can be prevented. And the cost of prevention is usually less than the cost of care after the damage is done.

But there is no assurance today that the school child who needs medical care will get it.

Many programs for reorganization of medical care in general are in progress today, and the time for reorganization of health services in schools is also here. Ways of pulling the two programs together must be found. That peculiar gift for organization, of which we Americans boast as our greatest asset, *can* solve this problem. But we must emerge from our current lethargy, must leave our individual and group selfishness behind, and must actually plan and execute a program of health for school children that brings to them the best we have to offer.

The careful reader may have noticed that nowhere in this discussion have the words "school health" appeared. We have deliberately avoided these words, hoping that emphasis on health for school children will point out that the time for change is here. And we believe that until all the skills now known to pediatrics, dentistry, psychiatry, psychology, nursing, sociology, and education are used, we shall not achieve our ends. Our so-called "school health" programs need to be scrutinized with a critical eye, and they must be measured against what American medicine can do. What phases of our program are effective and which are merely carrying out old routines? And though cooperation of workers in all these fields is essential, the medical and dental problems of school children will not be solved until competent medical and dental leadership brings about real programs, which assure every child effective medical supervision and care.

Reprinted from the *Yale Journal of Biology and Medicine*, March 1947.

every 1,000 live births, stillbirths numbered 26.7 in 1943, and 27.0 in 1944. Almost twice as many stillbirths per 1,000 live births occurred in the non-white as in the white population. Total loss of life, through stillbirths and neonatal deaths, came to 51.7 per 1,000 live births in 1944. Better care during pregnancy is essential if this rate is to be reduced.

Attendance at birth—Over the years improvement has definitely been taking place in the proportion of mothers and infants attended professionally at birth. Both in 1944 and 1943, 93 out of every 100 births were attended by a physician, either in a hospital or at home. 1944 showed an increase in the proportion of births taking place in hospitals (75.6 percent, as compared with 72.1 in 1943) and a corresponding decrease in deliveries at home under medical care.

Differences in attendance at birth between white and nonwhite and between urban and rural births help to highlight the areas where progress still needs to be made.

Against the 98 percent of white births—in both 1944 and 1943—which were attended by physicians stand the relatively low percentages for non-white births: 60 percent in 1944 and 57 percent in 1943. As late as 1944, that is, 4 out of every 10 nonwhite births occurred without any medical attention. The District of Columbia, which has a sizable Negro population, made an outstanding record in 1944, with practically 100 percent of both white and nonwhite births under a doctor's care. Of course, the District of Columbia is an urban area, and therefore its rate is not comparable with a State that averages rural and urban conditions.

All but 2 percent of the urban births in both 1944 and 1943 were attended by a physician, either in a hospital or in the home. Thirteen percent of the rural births in the same years received no medical care. An even greater difference exists in the proportion taking place in hospitals: for urban births, the percentages were 89 in 1944 and 87 in 1943; for rural, 57 in 1944, and 51 in 1943.

Recent developments in some American Republics

CHILE

Supervision of Child-Welfare Services Outside the Capital

Supervision over child-welfare services in Chile, outside the capital, was delegated late in 1945 to the National Bureau for the Welfare of Children and Youth, which has had charge of this work in the capital since 1942.

SOURCE: Diario Oficial de la República de Chile, December 26, 1945.

COLOMBIA

Improvement of Conditions in Institutions

According to regulations issued by the Minister of Labor, Health, and Social Welfare on August 21, 1946, every child-welfare institution must provide for the children medical and dental care, a general elementary education, and training in a trade or farming. Through social workers the institution is required to maintain relations with the child's family. Records must be kept and reports presented to the authorities supervising the institution.

Standards for foster-home placement and the duties of social workers in this work are also prescribed in the regulations.

SOURCE: Revista Colombiana de Pediatría y Puéricultura, June 1946.

THE DOMINICAN REPUBLIC

Social Insurance

The enactment of a social-insurance law in the Dominican Republic was proposed by the President of that country in December 1946.

SOURCE: Information Bulletin issued by the Dominican Embassy, December 23, 1946.

GUATEMALA

Social Insurance

Social insurance for all employed persons in Guatemala was the subject of a law of October 30, 1946. In case of illness insured persons will receive cash payments and medical and surgical care. The same care will be available for the dependent wife and children of the insured person.

The maternity benefits for an insured woman consist of a cash payment for a specified period of time and medical and surgical care in pregnancy, childbirth, and the postnatal period. Additional payments will be made to those who nurse their children. The law also provides benefits for widows and orphans of insured persons.

Measures are ordered for the enforcement of the law.

SOURCE: Diario de Centro-América, October 31, November 1, 4, and 11, 1946.

School Census

In compliance with an order of the President of the Republic, a census of school children was taken in Guatemala early in 1946. The purpose of the census was to ascertain the number of children of school age and of those who failed to attend school as required by law; also the reasons for their failure to do so.

PANAMA

Organization of National Council on Children and Youth

The organization of the National Council on Children and Youth (Consejo Nacional para Menores) in Panama was ordered by a law of September 27, 1946.

The council is to include the director of the Institute of The Child, the president of the National Board of Nutrition, and representatives of the National Red Cross, the Social Insurance Fund, and several Government departments.

The council is to meet at least twice a month. The members will serve without compensation.

The law has assigned to the council the following functions:

(1) Study of problems relating to children and youth;

(2) Promotion of the establishment of juvenile courts, vacation camps, school-lunch programs, and other services for children;

(3) Answering inquiries from Government agencies and private organizations and individuals and making recommendations to them;

(4) Cooperation with the Ministry of Labor, Social Welfare, and Public Health in matters relating to child welfare;

(5) Drafting a children's code;

(6) Organization of an annual child-welfare congress.

The council is authorized to establish in each province a child-welfare board, which is expected to cooperate with other agencies engaged in child-welfare work.

The council may use the services of persons trained in child welfare, whether they are residents of Panama or not.

The law establishing the council carries with it an appropriation for the work.

SOURCE: Gaceta Oficial, Panama, September 30, 1946.

New Constitution Adopted, 1946

The new Constitution, adopted in Panama in 1946, proclaims the duty of the State to protect the family and the child. To this end it orders the enactment of various child-welfare measures; it prohibits child labor in accordance with the internationally accepted standards, and it makes school attendance compulsory and primary and secondary education free.

In the matter of public health the constitution places on the State the functions of safeguarding motherhood, reducing infant mortality, instituting medical supervision over school children's health, and providing adequate food for mothers and children. It also orders the establishment in each locality of sufficient hospitals, general clinics, and dental clinics, with free services to persons of low income.

Anna Kalet Smith.

Texas organizes committee for children and youth

The Texas Committee for Children and Youth was organized in November 1946, with Mrs. George H. Abbott of Dallas as chairman. The purpose of the committee is "to assemble and distribute facts pertaining to the needs and care of children and youth in Texas, and to coordinate the efforts in behalf of their health, education, and social welfare." Membership is open to "any agency, organization, or person interested in the objectives of the organization."

Planning for a committee started last spring in a meeting of representatives of some 50 State-wide organizations and agencies, called by the Texas Social Welfare Association. The by-laws of several State committees were studied, and those of the Kansas Council for Children chosen as the type which seemed to be most suitable for the purposes of the proposed committee.

The participating groups were definite in their thinking that the Texas Committee for Children and Youth should be organized primarily to study, plan, and coordinate.

Stella Scurlock.

Correction: The price of "Bibliography of Books for Children" published by the Association for Childhood Education is 75 cents. Through a typographical error it was incorrectly reported in the January *Child* as 5 cents.

Children not to blame for most damage in homes, survey shows

Relatively few of the common types of tenant wear and tear on rental properties can be attributed to children, the Federal Housing Agency reports.

A survey of the most common types of misuse and breakage occurring in public low-rent housing in the United States showed that housewives often caused more damage than children, frequently by ill-advised cleaning methods.

The findings are particularly significant in view of the Government's recent plea to landlords not to ban families with children from their properties. Some landlords refuse to rent to such families because they believe children cause extra maintenance and repair costs.

SOURCE: *FPIA Bulletin*, December 1, 1946. Federal Public Housing Authority, National Housing Agency.

American Legion adopts resolutions on child welfare

Since approximately half the youth of America are the children of veterans, the American Legion feels that if the living conditions of veterans' children are to be improved, the Legion must work for the betterment of the living conditions of all children.

At its 1946 annual convention, held in San Francisco October 3, the Legion reaffirmed the goal of its established child-welfare program, "A Square Deal for Every Child," and voted to extend the program more widely. The American Legion's child-welfare program, first adopted at its 1924 convention, is described as a program to serve the whole child in his physical, mental, emotional, and spiritual well-being.

According to the resolutions adopted at the convention the Legion plans a number of steps, among which are the following:

(1) To work for State and national increases in appropriations under the Social Security Act for aid to dependent children.

(2) To recommend that public-assistance funds be based upon the needs of the child rather than set as a fixed sum; and that the practice of prescribing a maximum allowance for aid to dependent children be abolished wherever such exists.

(3) To appoint an advisory committee consisting of representatives of various faiths to assist in the preparation of booklets on religious instruction.

(4) To recommend that eligibility for crippled children's care and treatment under the Social Security Act be

determined by a medical decision, thus eliminating the necessity for court action.

(5) To reaffirm the "Children's Charter" of the 1930 White House Conference and strive to accomplish its objectives.

(6) To cooperate in efforts on juvenile delinquency and in aiding youth to make America a better place in which to live.

(7) To work to eliminate publication and distribution of salacious and obscene literature.

(8) To work to substitute wholesome radio programs for those dealing with crime and easy money.

(9) To work in the States for adequate standards and equipment for prevention and treatment of juvenile delinquency.

Stella Scurlock

CONFERENCE CALENDAR

Mar. 12—Girl Scout 35th Anniversary Day. Girl Scouts, 155 East 44th Street, New York. Slogan: "Better Citizens Build a Better World."

Mar. 13-15—American Camping Association, New York.

Mar. 23-29—Play Schools Association. Annual conference. New York.

Mar. 30-Apr. 6—National Negro Health Week.

Apr. 13-19—National Conference of Social Work. San Francisco.

Apr. 20-26—Public Health Nursing Week. Further information from the National Organization for Public Health Nursing, Inc. 1790 Broadway, New York 19.

Apr. 21-26—American Association for Health, Physical Education, and Recreation. Annual convention. Seattle, Wash.

May 2-3—American Council on Education. Thirtieth annual meeting. Washington.

●
School children like the boy on our March cover should not lack effective health services in the country with the richest medical resources in the world. Library of Congress photograph by John Vachon, for Farm Security Administration.

Other credits:

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Page 147, photograph by Larry Schreiber for St. Paul Community Chest.

Page 149, photograph by Peter Skaer for Federal Public Housing Authority.

Page 155, Library of Congress photograph by Marjory Collins.

Page 156, Children's Bureau photograph.

Page 157, photograph by E. A. Powell for South Carolina State Board of Health.

ELLEN WILKINSON NEVER GAVE UP

When death claimed Ellen Wilkinson, Minister of Education in the British Labor Government, on February 6, not only Britain's children but children everywhere lost one of their greatest friends and most spirited protectors. The legacy she leaves them is the vivid memory of herself as a person and the example of the fearlessness and devotion of her career as citizen and as Minister.

What she wanted was a fair start for all children, and public responsibility and participation in the upbringing of generations of healthy and educated citizens. The "sins" of the fathers and mothers—their poverty, ignorance, and ill-health—she felt should not be visited on the children.

Once, listening to her speak in the House of Commons, an old gentleman sitting beside me in the visitors' gallery leaned over and whispered: "Remember Chesterton's poem, 'For these are the people of England and they have not spoken yet?' They're speaking now. She's speaking up!"

Millions, both in her own party and outside it, felt for her the affectionate respect the GLs had for the jeep. She never gave up when the going was rough.

Her childhood was spent in a slum in

Manchester. She was the daughter of a cotton-mill worker who never earned more than \$16 a week in his life. Scholarships got her her education from the time she was 11. She got her M. A. degree in history from Manchester University.

When she was 31 she was elected to Parliament by the Middlesbrough East Division as Labor Member, a seat she held from 1924 to 1931. In 1935 she was again elected to Parliament, from the Jarrow Division of Durham, and this seat she held until her death. She was always among the first to protest against injustice. She was impulsive and eloquent, and within her party organization and outside she became a proponent of the individual's right to speak.

During the recent war she served as parliamentary secretary to the Ministry of Pensions and later as parliamentary secretary to the Ministry of Home Security. In 1945 she became the second woman in history to hold office as a British Cabinet Minister.

As Minister of Education, she was charged with providing schoolhouses and teachers for a greater proportion of English children than ever before. Better education and more of it was her slogan, as the way to rebuild victorious but blighted England. Hers was the job of administering the program under the law raising the school age from 14 to 15. Hers was the job of administering a

commitment of spending \$95,000,000 for new school buildings. England can ill spare her competence, imagination, and courage.

But the work she did in helping to prepare the plans for UNESCO—the United Nations Educational, Scientific and Cultural Organization—remains as well as her persuasive faith that care for children's health and education is the broad base of any nation's future.

What fathers and mothers covet for their own children, they should covet and create for all. Ellen was that way. If by her witty journalism, she earned an iceless refrigerator, or a little car, she immediately wanted others to share them and to possess duplicates.

She wanted to educate the people to create, to find power for making things, rather than for destroying them in an atomic age.

She practiced patience and impatience, found fun in hard work and more fun in harder work, understood the technical machinery of modern industry and civil administration, and yet maintained a private life of devotion to an invalid sister, and delight to many friends. She firmly believed that you had to work harder in peace than in war, lest further wars betide.

Everett Ruess

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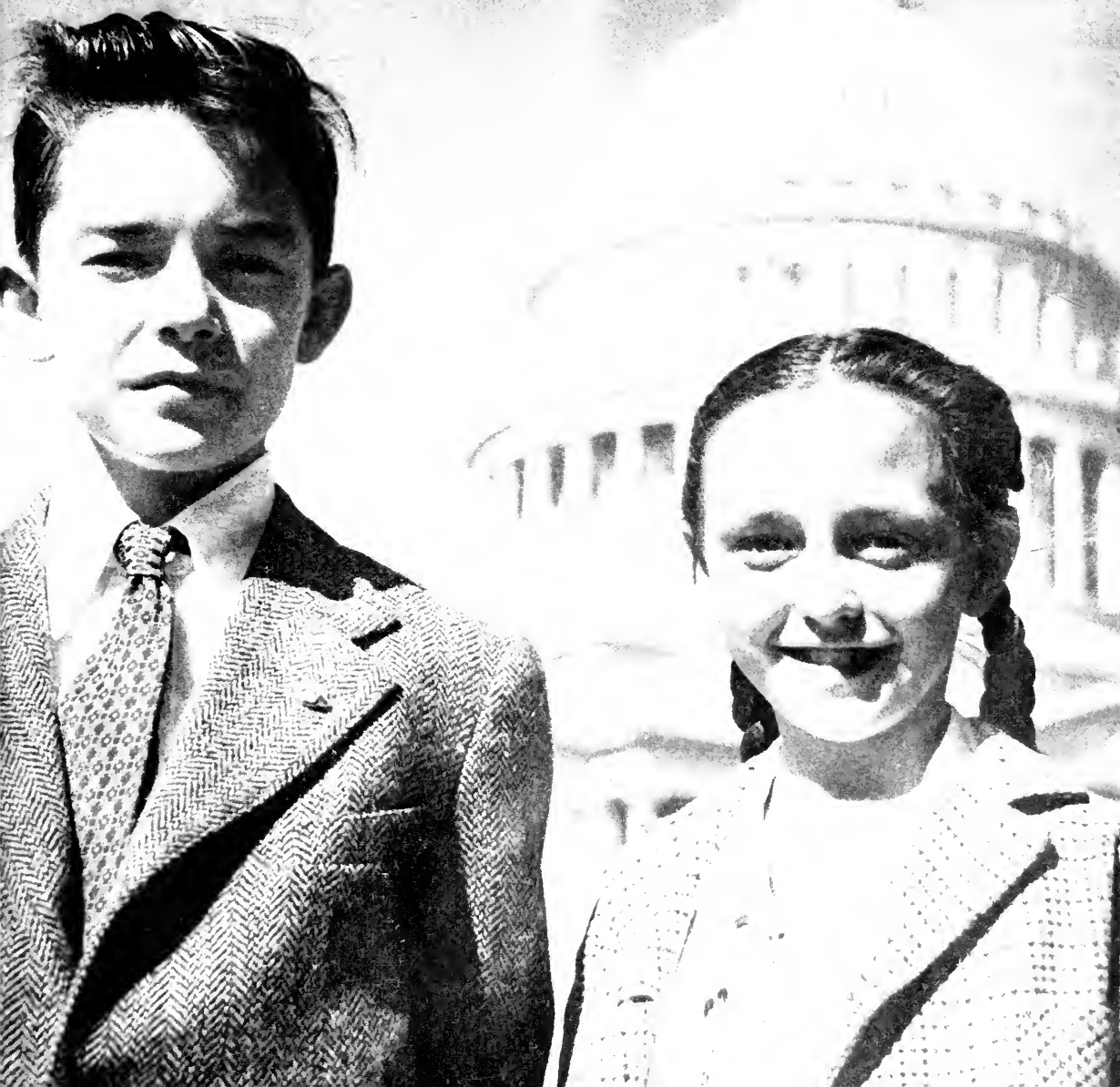
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THE

APRIL 1947

CHILD



PREAMBLE TO THE CONSTITUTION OF UNESCO

The governments of the states parties to this constitution on behalf of their peoples declare

that since wars begin in the minds of men, it is in the minds of men that the defenses of peace must be constructed;

that ignorance of each other's ways and lives has been a common cause, throughout the history of mankind, of that suspicion and mistrust between the peoples of the world through which their differences have all too often broken into war;

that the great and terrible war which has now ended was a war made possible by the denial of the democratic principles of the dignity, equality, and mutual respect of men, and by the propagation, in their place, through ignorance and prejudice, of the doctrine of the inequality of men and races;

that the wide diffusion of culture, and the education of humanity for justice and liberty and peace are indispensable to the dignity of man and constitute a sacred duty which all the nations must fulfill in a spirit of mutual assistance and concern;

that a peace based exclusively upon the political and economic arrangements of governments would not be a peace which could secure the unanimous, lasting, and sincere support of the peoples of the world, and that the peace must therefore be founded, if it is not to fail, upon the intellectual and moral solidarity of mankind.

For these reasons

the states parties to this Constitution, believing in full and equal opportunities for education for all, in the unrestricted pursuit of objective truth, and in the free exchange of ideas and knowledge, are agreed and determined to develop and to increase the means of communication between their peoples and to employ these means for the purposes of mutual understanding and a truer and more perfect knowledge of each other's lives.

In consequence whereof

they do hereby create the United Nations Educational, Scientific, and Cultural Organization for the purpose of advancing, through the educational and scientific and cultural relations of the peoples of the world, the objectives of international peace and of the common welfare of mankind for which the United Nations Organization was established and which its charter proclaims.

IF CIVILIZATION is to survive we must cultivate the science of human relationships, the ability of all peoples of all kinds to live together and work together in the same world at peace."

Franklin D. Roosevelt wrote that the night before he died, and his words seem like a preview of what the United Nations Educational, Scientific, and Cultural Organization (UNESCO for short) is now trying to do.

What is UNESCO trying to do? It is trying to bring about mutual understanding among the peoples of the earth, and in so doing to fulfill the purpose of the United Nations; namely, to keep the peace. For though understanding is no guaranty of peace, there can be no lasting peace until there is understanding.

UNESCO became a reality as a specialized agency of the United Nations in November 1946, when the twentieth nation accepted membership. Thirty members now belong, and more nations are expected to join.

With Dr. Julian Huxley, the eminent biologist, of Great Britain, as Director General, UNESCO has set its tasks for 1947, on a budget of 6 million dollars.

Its activities will be carried on within the borders of any member country only when authorized by the government of that country.

UNESCO has drawn upon the experience of other international agencies, such as the Institute of Intellectual Cooperation, which the French Government established in Paris under the aegis of the League of Nations, and which now works with UNESCO.

But UNESCO has a broader aim than to unite the intellectuals, the learned. It wants the *people* of every land to understand the people of every other. A large order, but worth trying to fill.

TOWARD PEACE THROUGH UNDERSTANDING

KATHARINE F. LENROOT,

*Chief, U. S. Children's Bureau, and Member of the
United States National Commission for UNESCO*

UNESCO's beginnings were warborn. During the German invasion of Europe a number of Allied Governments temporarily established themselves in London. The ministers of education of these governments held informal meetings, and out of these meetings developed the Conference of Allied Ministers of Education.

The ministers began assembling information about the damage done to educational institutions in their countries and undertook a study of what might be needed to restore them. And they invited the United States and other nations to join them.

United States takes part

Early in the following year (April 1944) the United States sent a delegation to the Conference. Soon proposals were drawn up for a United Nations agency for educational and cultural reconstruction in the occupied countries. These proposals included a suggestion of what was to come 2 years later; for they provided that the agency should take the necessary steps "to create an international organization dedicated to the proposition that the free and unrestricted education of the peoples of the world and the unrestricted interchange between them of ideas and knowledge are essential to the preservation of security and peace." The proposals were submitted informally to the various Allied Governments for study and comment.

From this time on the United States participated actively in the work of the Allied Ministers of Education.

During the San Francisco Conference at which the United Nations Organization was established, the movement for a permanent international educational and cultural organization went forward. Early in the conference period the governments accepted a pro-

posal by the Chinese Government that educational and cultural cooperation be specifically included among the major objectives of the United Nations Organization.

During the early weeks of the Conference public interest in this subject, which had been gaining rapidly during the previous 2 years, continued to grow. The consultants group of the United States Delegation, composed of men and women designated by 42 national organizations and representing labor, business, and agriculture, women's activities, religious groups, and war veterans, as well as formal education, agreed on the necessity of assuring the place of education and international cultural relations in the United Nations system, and felt that such assurances could be given only by having the subject specified in the Charter.

After a special reference to "educational and cultural cooperation" was included in the United Nations Charter (art. 56), the French Delegation sent a memorandum on cultural cooperation to the Technical Committee on Economic and Social Cooperation, recommending that the members of the United Nations convene a conference to draw up a Statute of an International Organization on Cultural Cooperation.

The French memorandum was unanimously approved by the Conference; it contained a definite proposal for an international organization designed to go much farther than the old conception of intellectual cooperation.

While the San Francisco Conference was in progress, each of the two houses of Congress adopted a resolution urging that the Government of the United States participate in the creation of an educational and cultural organization by the nations of the world.

Soon, a meeting to consider the new organization was set for November 1, 1945, in London.

In the United States, organizations interested in educational and cultural matters and leaders in all fields of American life and thought joined with the United States Government in preparing for the London Conference.

If these high-school boys can learn more about how boys in other lands think and feel, a few steps will be taken toward peace.



In London, on November 1, representatives of 44 nations gathered under the presidency of the late Ellen Wilkinson, then Great Britain's Minister of Education. In 16 days they had agreed on a constitution, which stated the organization's purpose as:

* * * to contribute to peace and security by promoting collaboration among the nations through education, science, and culture, in order to further universal respect for justice, for the rule of law and for the human rights and fundamental freedoms which are affirmed for the peoples of the world, without distinction of race, sex, language, or religion, by the Charter of the United Nations.

A Preparatory Commission was established by the Conference to plan the first General Conference of the Organization, set for a year from then.

The Conference established the seat of the Organization at Paris, although this location can be changed by a two-thirds vote.

A few months after the Preparatory Commission began to get ready for the first General Conference, which was to take place in November 1946, congressional committees began to hold hearings on proposed legislation to enable the United States to join the Organization. Both houses eventually passed this legislation, and President Truman signed it July 30, 1946, saying, "If peace is to endure, education must establish the moral unity of mankind." The law authorized the President to accept membership in UNESCO for the United States and directed him to appoint five delegates to the General Conference after consulting the National Commission for UNESCO.

As yet no such Commission was in existence, and the law directed the Secretary of State to organize it. The plan for the Commission originated in the constitution of UNESCO, which says:

Each member state shall make such arrangements as suit its particular conditions for the purpose of associating its principal bodies interested in educational, scientific, and cultural matters with the work of the Organization, preferably by the formation of a national commission broadly representative of the Government and such bodies.

The constitution also says that when such a commission exists in the nation it shall act in an advisory capacity to its government and to the government's delegation and as liaison agency in matters connected with UNESCO.

Since one of the chief purposes of the National Commission is to associate the work of private organizations with UNESCO, the law requires that 60 of the 100 members be representative of non-governmental organizations.

The Secretary of State at once began organizing the National Commission. After months of consultation with experts in education, natural science, social science, arts and humanities, and the media of mass communication, he invited 50 national organizations to nominate members to the National Commission, and later named 40 additional

round table was provided with a number of reports that had been prepared by advisory groups.

The Commission's final report recommended that in view of the urgency of developing a sense of international solidarity as a firm basis for the United Nations, the major part of the resources and the personnel of UNESCO should at this time be expended on activities aimed directly toward the dissemination of men's knowledge of themselves, their world, and each other, through all the instruments of communication.

The report of the National Commission



These Italian youngsters have no school to go to; it was bombed out of existence. But there is hope for rebuilding such schools.

persons. The National Commission met from September 23 to September 26, 1946, at Washington.

In order to advise the United States delegation, the members of the National Commission studied the program that had been laid down by the Preparatory Commission for consideration at the coming Paris conference. This program was organized in seven sections: Creative arts, Cultural institutions (museums and libraries), Education, Humanities, Mass communications, Natural sciences, and Social sciences. Accordingly the Commission organized itself into seven round tables, each to consider one of the sections. Each

section also urged that greater emphasis be placed upon these objectives in the work to be undertaken by UNESCO in relation to recognized educational systems. Similarly, the commission urged that UNESCO promote the fullest possible use of media of mass communication for these ends, not only by promoting the free interchange of information and ideas but also by influencing, through appropriate methods, the quality and content of films, radio programs, and the press.

Giving consideration to the problems of educational relief and rehabilitation in war-devastated countries, the National Commission expressed a full and



Little Wu finds it hard to understand some of our ideas, and we cannot understand some of his. But all of us can still learn.

vigorous concern that the United States give every assistance within its power, and a resolution was passed to that effect.

The first general conference of UNESCO opened November 19, in the amphitheatre of the Sorbonne at Paris, under the flags of the 44 nations represented. Leon Blum, former premier of France, presided.

The formal task of the conference was to draft a program of activities, authorize a budget, and devise an administrative structure. Its real mission as described in a report by the United States delegation was to give life and substance to an untried experiment in international relations.

The Preparatory Commission had listed hundreds of suggested activities in its report to the Conference as a basis for discussion, and the Program Commission asked its subcommittees to judge each proposal according to the following criteria:

Does the undertaking contribute to peace and security? (In this sense it was meant that the word peace should mean not a mere absence of overt hostilities, but a condition of mutual confidence, harmony of purpose, and coordination of activities, in which free men and women can live a satisfactory life.)

Do the separate undertakings form a coherent total program? Is the under-

taking financially feasible? Is it feasible in terms of available staff? Does the undertaking represent the most appropriate way to achieve the desired result? Should the undertaking be begun during the coming year, or should it be approved and postponed? Are the undertakings few enough in number and important enough to form a practical and challenging program?

Out of the many undertakings that the general conference approved last December, at Paris, has emerged a general plan for action in 1947. The undertakings fall into three general classes:

The first consists of "UNESCO-wide projects," in which practically all the subject-matter sections of the Organization will take part.

The second includes projects carried on within these sections.

The third is made up of continuing services, which will go on from year to year as a regular feature of UNESCO's work.

The UNESCO-wide, or over-all, projects include efforts toward: (a) Educational reconstruction and rehabilitation; (b) International understanding; and (c) Fundamental education.

The first UNESCO-wide project is for educational reconstruction and rehabilitation. UNESCO is not a relief agency, but it realizes that it can do

little with an educational, scientific, or cultural program while the war-devastated countries are in their present condition. In those lands thousands of schools are in ruins; books, pencils, paper, maps, and all kinds of educational equipment are almost completely lacking; and children are still hungry and without warm clothing. Besides, there is a great lack of trained teachers to replace the many who have lost their lives.

UNESCO's job here is to stimulate and coordinate action by individuals and organizations in raising money and collecting materials for educational relief. National commissions and similar bodies cooperating with UNESCO are working in their own countries with voluntary organizations set up for the purpose. A number of these organizations met in Paris under the auspices of UNESCO in February 1947, and began a campaign to collect money, and also to collect every sort of educational equipment, from costly apparatus down to pencils and paper.

Provision of educational, scientific, and technical equipment is an important separate task in the reconstruction program. Schoolbooks, language primers, literary classics, historical works, reference books, library filing drawers, and binding and book-repair materials are only a few of the many items that are urgently needed.

Clearinghouse for fellowships

Another program for which UNESCO will act as a clearing house is a plan for awarding fellowships to selected specialists in war-devastated countries.

As part of its general reconstruction project, UNESCO will work with student organizations and other agencies to promote establishment of youth-service camps in devastated areas for the summer of 1947.

Second of the UNESCO-wide projects for 1947 is a five-point effort toward teaching international understanding in schools and colleges. UNESCO will inquire into the way in which international relations are taught in schools and colleges and try to make needed information available to them. It will further international-relations clubs. It will hold a seminar workshop in Paris, in summer, for teachers. It will investi-

(Continued on page 175)

WHAT RHEUMATIC FEVER MAY MEAN TO A CHILD

ETHEL COHEN,

Director, Social Services, Beth Israel Hospital, Boston

IN MEDICINE, as in other fields, there is considerable lag between the development of a theoretical concept and its application to concrete situations. The idea that care of the sick requires consideration of the patient as a whole is not new. It has been accepted for centuries; it has been the subject of lectures in medical schools for many years; it was made a reality by the insight and understanding of many family doctors; but only recently has it begun to be applied in practice in an organized way.

In rheumatic fever the influence of emotional and social elements is strong. And the lag between knowledge and practice concerning these elements seems especially great.

We do not know just what causes rheumatic fever. But we know that both treatment and prevention are inextricably bound up with emotional, social, and environmental problems.

As for the nature of the disease, a Children's Bureau Bulletin, "Facts About Rheumatic Fever," tells us that rheumatic fever is a disease of childhood, usually appearing first when the child is 7 or 8 years of age. Often the child's illness is serious, painful, and disabling. It is likely to confine him to bed for long periods, and it may recur again and again.

It removes the child from school, from his usual association with his friends. It keeps him from competing with other children in play. It prevents him from testing and strengthening his capacities.

We can readily see what serious effects such an illness can have on a child, no matter how favorable his economic or personal circumstances. For in these early years every child should be developing his body, his personality, and his relationships with his family and with the outside world.

Let us look at what we think of as

the minimum requirements for the development of a healthy, well-adjusted child: Parents who love and understand him, harmonious family life, a safe and sanitary home, sufficient nutritious food, adequate clothing, good education, wholesome play and recreation, and good health supervision. All these a child needs in his early years when he is forming habits that will influence his future life.

Normal life interrupted

Suppose a child who has had these minimum requirements for normal development becomes ill with rheumatic fever. The family may be in good economic circumstances; they may find it easy to obtain good medical supervision for their child and to fulfill his basic physical needs; and they may be able and willing to devote sufficient time to his care. But even then there will be a problem of interrupted normal development. And the illness may stir up latent psychological or emotional difficulties in the child as well as in others. The child may become overdependent and invalidated, rebellious because he cannot share the play and other interests of his brothers and sisters and friends, and may be envious of them. Being "different" from the others, he may feel insecure. Becoming ill again and again, he may be afraid that he will never recover.

If rheumatic fever can cause all these difficulties for a child whose home life is satisfactory, how much more can it do to a child whose home life is unsatisfactory?

Such a child was Mary Smith, 8 years old when she was taken ill with rheumatic fever and sent to a general hospital. Her illness reactivated and intensified emotional problems that had been latent since her mother's suicide, when Mary was 3 years old. Fortunately, the medical-social worker and

the doctor at the hospital's cardiac clinic were able to recognize Mary's emotional problems, and to realize that consideration of these problems was as important to her recovery as was the medical treatment of her illness.

Mary came to the attention of the medical-social worker after she had been ill in the hospital a little more than 2 weeks. An intern had asked the worker to help in planning for the long-time convalescent care that Mary would need after she was discharged from the hospital, which would be in about 3 weeks.

The care that the child needed would include complete rest in bed for an indefinite period of time, without being allowed up for meals or for the toilet, and the intern doubted whether adequate care could be given the child at home. She was living at the time with an uncle and aunt and their three children, on the second floor of a duplex house. Her father worked and lived in a distant community.

Mary's father came to see the medical-social worker at once. He showed considerable anxiety and was tense and flushed as he talked about his fears that Mary's heart would be damaged and that she would be handicapped in the future. He was worried, too, about what influence this would have on his own future.

He told the worker that his wife had committed suicide 5 years before, while he was seriously ill in a hospital in another State, and while Mary and her mother were staying with the mother's relatives, sharing a room. He did not think Mary knew what had happened to her mother, except that she had died.

Mary changes homes

He and his wife had been happily married, and he had had no inkling of any suicidal ideas, although he learned later that a psychiatrist had warned his wife's relatives that she might commit suicide, a few days before she did so.

After his wife's death, Mr. Smith had placed Mary in a private school, as her mother's relatives took no interest in her, and his own mother was old and had a chronic illness. When he could no longer pay the school fees, he boarded Mary in his brother's home, where she was living when she became ill with rheumatic fever.

Mr. Smith himself was living with his aged father and mother in the community where he worked, which was 60 miles from the city where Mary was boarding. He had been giving a great deal of time to Mary, for he felt that he had to be both father and mother to her. He felt responsible for the death of her mother, for he felt that if he had been well and had been able to be at home she would not have killed herself. He had some idea of marrying again, and if he did he expected to have Mary live with him in his new home. He had had some difficulties in connection with the possibility of remarrying, however, as the amount of time he gave to Mary caused him to neglect his social life.

Complete rest needed

The case worker gave Mr. Smith every opportunity to express his feelings, and then talked with him about Mary's need for convalescent care. At a conference with the intern and the case worker, Mr. Smith learned more about the kind of care that a rheumatic-fever patient requires. He was told about Mary's need for complete rest for an indefinite time, depending upon her progress as shown by medical examinations and laboratory tests.

The father agreed that adequate rest would not be possible for Mary in the

home of her uncle and aunt with the three active children; and he said that the aunt would not be able or willing to give the amount of care that Mary would need after she left the general hospital. He agreed that when the time for discharge came she should be sent to a special hospital for children with rheumatic disease.

Worker and child become friends

During the 3 weeks that remained of Mary's stay in the general hospital, she and the medical-social worker talked together every day. Mary was an attractive, pleasant child, with an appealing, friendly manner. She talked with the social worker at great length about herself, her father, and his girl friend. She talked also about her dead mother and told how she disliked her mother's relatives. And she told the worker how much she liked the uncle and aunt and cousins with whom she was living.

Mary talked a good deal about death, and through these conversations the worker got the impression that the child knew about her mother's suicide. Mary also showed that she felt a lack of continuity in personal relationships. On several occasions she said to the worker, "As soon as I get to know someone I move away and never see them again." The worker realized that this lack had

become a serious problem to the child, and tried to develop a sustaining relationship upon which Mary could depend.

The child was much distressed when she learned that she was not going back to her aunt's home at once when she left the general hospital. Her father and the worker carefully explained the reasons. When Mary realized that her father would be worried about her if she did not have the best care possible she felt more willing to go to the special hospital.

Her father would not be able to see her often, as the visiting hours were difficult for a person who had to come from another town.

Mary clung to the case worker, feeling that she was about to be separated once more from a person with whom she had formed an attachment. She asked if the worker would visit her at the hospital and write to her, and the case worker agreed to do so.

Physical and psychological needs

After 3 months in the special hospital, Mary was ready for discharge, but she was to remain under the supervision of the general hospital's cardiac clinic. At the time of her discharge her father wished to have her go away with him to the mountains for his 2-week vaca-



Studies indicate a direct relation between rheumatic fever and damp, dark, overcrowded homes.



Basket weaving keeps Johnny from being bored in the hospital after an attack of rheumatic fever.

tion. The clinic doctor had some doubts about the wisdom of this trip. But he gave his consent, realizing that Mary was intelligent and mature, and that she understood her illness and the reasons for restricting her activity. He appreciated also the child's psychological need for the vacation with her father.

The vacation was a great success in every way. After it was over Mary continued to improve, and after about 3 months at home she returned to school full time and resumed her normal activities. This was 7 months after she was first taken ill.

Six months after she went back to school, the cardiac clinic found her heart "negative"; she had had no colds and no pains in the joints, felt "wonderful," and was doing well in school.

In both Mary and her father there had existed, before she became ill with rheumatic fever, many emotional problems. Recognition of these problems, and sensitive treatment of them by the case worker and the physician undoubtedly prevented greater emotional breakdown and contributed significantly to the satisfactory outcome of the case.

Child needs decent home

Long experience with the problem of rheumatic fever has convinced me that most of us from time to time need to examine critically some of the practices with regard to children with this disease whose homes do not provide anything near the minimum requirements for the child's normal development.

Lacks in decent living conditions are frequently accepted as a matter of course. Sometimes we attempt to give financial help, or psychological help if the client asks for it or is "ready to accept it." Or some of us dogmatically decide that something constructive can or cannot be achieved with a given individual or family. These assumptions are dangerous, for our knowledge of human potentialities for growth is still pretty limited. On the basis of a decision that nothing constructive can be done, we may deny services that in the long run would benefit not only the individual and the family but also the community.

Recently I heard a conscientious,

well-intentioned case worker discuss a family situation, focusing her remarks on a psychological problem resulting from religious prejudice. The family had been originally referred to the agency by a hospital because one of the children had rheumatic fever. The case apparently had been active with the agency for a number of years, and then closed. Some time later the same hospital requested that the case be reopened because another of the children was in a very dangerous condition because of malnutrition.

In the worker's original discussion she had not given any description of the home. Later, however, in speculating as to whether the mother could have been helped to understand her attitudes about the problem concerning religious prejudice, the worker described with revulsion the utter physical disintegration of the home. She also remarked that of course no case-work agency in the community would touch the case because of the mother's low mentality and neglected home. The public-welfare allowance did not begin to meet the family's budgetary needs.

This case had been known for years by an excellent hospital and by other agencies. But in all that time it seems that no really whole-hearted attempt had been made to do first things first; namely, to ensure for the children a decent, clean home, and adequate, nutritious food. Improvement of the general health of a family of children in which rheumatic infection was already present should have been accepted by any case worker as her professional responsibility. The interests of the individual children and of the community would thus have been well served. It is possible that the mother's intellectual capacity was limited. However, it is also possible that she might have been able to plan properly for her family if she had ever had sufficient funds for even their minimum needs, before her discouragement became so profound and paralyzing.

Dark, damp, overcrowded

Besides the emotional factors in rheumatic fever, the environmental factors must be considered.

Epidemiological studies of rheumatic fever, in the United States and England, show a direct relationship

between the dark, damp, overcrowded homes and the incidence of rheumatic fever.

If rheumatic fever has affected a child's heart, and he has developed rheumatic heart disease, efforts are sometimes made to help the family move to first-floor quarters. But too little effort has been made to improve the environment earlier so as to prevent recurrence of rheumatic illness and to retard the progress of the disease.

Social workers do not, of course, have the sole responsibility for bringing about changes in the environment of children with rheumatic fever. Physicians, with the weight of their medical experience and knowledge, should cooperate with social workers and community organizations in mobilizing local and State governments to enforce existing housing statutes and to create new legislation under which unsanitary housing conditions will be corrected, and dwellings that cannot be improved will be replaced with health-protecting homes.

Medical care wasted

An eminent cardiologist recently spoke with feeling about the futility of expensive long-time medical care for sick children, without provision by the community for their elementary physical needs. He told of a youth, handicapped since childhood with rheumatic heart disease, who suddenly decided to abandon the efforts he had been making to follow the doctor's advice. He was "fed up with the whole thing," he said, because in spite of his efforts to follow the medical recommendations, he had had a recurrence of the illness in each of the past 5 years.

On closer inquiry, the cardiologist learned that the boy shared a bed with four brothers, two of whom also had rheumatic fever, and he was continually picking up a cold from one or another of the brothers.

Since one of the most common and serious influences in the recurrence of rheumatic fever is streptococcal infection of the nose and throat, avoidance of such infection is imperative. Every child with rheumatic fever should have a bed to himself, which he needs not only for complete rest but for avoidance of infection from others.

It is well known that rheumatic fever is prevalent among people of low economic status. If a child in such a family has a protracted illness, usually the income has to be supplemented to provide for his nutrition, and public relief should become flexible enough to take account of such needs. Although some public-welfare officials recognize and act upon this, in too many communities public relief does not yet meet the basic minimum budget for the needs of a family, even in health. At times an additional allowance of \$1 a week is made when there is illness in a family, regardless of its nature. This extra dollar was pitifully inadequate several years ago; today it is meaningless. Community councils and welfare boards have responsibility to gather data on this problem, and to make the necessary changes in agency budgetary allowances, whether the agencies are privately or publicly financed.

When a child has rheumatic fever there is sometimes a question as to where he should be cared for. If conditions in his home are favorable, this is the best and most natural place for him. But often the mother will need reassurance from time to time so that she will not be overanxious about the child's condition and so that she will not overindulge a child who tends to dominate the home.

Real rest in bed over long periods of time will not be possible unless the child or adolescent learns to take an interest in quiet games, reading, or study. Public schools sometimes supply bedside teaching in the home. In some communities clubs finance home visiting by occupational therapists. Hospitals might well extend such a service to their patients.

Child needs a place to rest

For some sick children home is not the best place. The mother may be physically or psychologically unsuited to caring for a child with rheumatic fever; or there may be so many sisters or brothers that real rest is impossible; or the behavior of the sisters and brothers may interfere with the patient's rest. Or the home may be physically unsuitable; it may be in an overcrowded tenement district, or a shack by a river, or on a steep hillside in a rural area. (Too often living in a rural district is of itself considered healthful; but probably in every section of the United States some rural housing is as bad as the worst urban conditions.)

Helping a family to move is almost impossible today on account of the housing shortage. But even in the past it was difficult. Sometimes parents do not understand the need for a change,

or lack interest, or do not wish to move from familiar surroundings.

Frequently a child ill with acute rheumatic fever needs care that is available only in a good hospital. During the long time needed for rest after he is discharged from the hospital, he will need special care. If his home is unsuitable he should be cared for in a sanatorium, or a hospital ward specially arranged for this kind of care, or a foster home. Unfortunately most communities are completely lacking in these resources. Where they do exist, the choice among them will depend upon full knowledge of the individual child, his family, and his environment. The choice is best made after joint consideration by the doctor, the social worker, the family, and the public-health nurse, with the child participating if this is feasible.

Full knowledge of the child often can be attained only through a home visit by a social worker, or by a public-health nurse in communities where this has been agreed upon as one of the nurse's functions. Unfortunately the practice of visiting patients' homes has declined greatly. A skillful office interview is valuable, but there is no substitute for a home visit when a child has rheumatic fever or rheumatic heart disease.

(Continued on page 175)

In a convalescent home for children the house mother helps these little girls to keep busy and happy. George's doctor has recommended that he stay in his own home for care after rheumatic fever.



Groundwork for more effective home finding in Ramsey County, Minnesota.

IN EVERY CITY, town, and stretch of open country are children who need a special kind of help. Deprived of home life with their own parents, they urgently need substitute homes where they can feel that they are part of a family. Help in finding these boarding homes must come from every direction; it is already coming from many. Clergymen from their pulpits tell of these children who can go ahead with normal living even after an upsetting experience, if they are welcomed into another family. Newspapers, the radio, and other channels of communication have told these children's stories, some well, some badly, depending usually on the quality of the material given them by case-work agencies.

For children's workers, boarding homes have become an indispensable tool. They know that if not enough homes are known they must "dig deeper" in their home finding, much as the giver is often urged to dig deeper in a campaign for funds.

Obviously, a first step in digging deeper to find homes for children is to find out what homes are known and how well they are used. This the Child-Welfare Division of the Ramsey County Welfare Board has done in St. Paul, Minn., with the help of the research department of the Wilder Charity of St. Paul.

The persistent demand for more and more boarding homes for children and the scarcity of known homes has led the researchers to question, in their report, whether the foster home is disappearing from the American scene. Has the American home shrunk so much in size, they ask, that the household no longer has extra living space for a child even if the family wishes to give a child haven and is qualified to do so? The report does not suggest abandoning the search for foster homes; it does give information on boarding homes in use by one children's agency, information that should help St. Paul to augment its supply of boarding

homes and should be of value to other agencies in planning a search for new homes.

What are the homes like?

The study analyzed the 304 licensed boarding homes in use by the welfare board's child-welfare division on August 31, 1946. The division inquired about the family income, about home ownership, about the number of rooms in the home, and about the marital status of the foster parents. How old was the boarding mother? How long had she been accepting children from the child-welfare division for boarding care? Where was the home located? How many children were in the home in relation to the number permitted there by the license? And, an especially important question in connection with the search for boarding homes, how did the foster parents become interested in offering their home for this service?

Information on income was obtained from 249 of the 304 families, or 8 out of every 10. The monthly amounts ranged from \$50 to about \$550. Most of the boarding-home parents owned their homes—85 percent, in contrast to the 15 percent who rented.

The average number of rooms per dwelling was about 6 in the houses owned by the foster parents; it was about 5 in the rented houses.

Most of the people who acted as foster parents in these boarding homes were, as would be expected, couples married and living together, although somewhat less than 8 percent of the boarding mothers were widowed and about 2 percent were single, or separated or divorced from their husbands.

The age of a boarding mother and the length of time she has been taking care of children for the child-welfare division is significant. The study revealed that in this group of mothers the age ranged from 25 years to 74. A fourth of the mothers were younger than 38, half were between 38 and 53, and a fourth were older than 53.

The length of time each mother had

taken part in this placement service seems to show that the mothers usually begin this work after their own children are beyond early childhood, inasmuch as most of the mothers who accepted children for foster care for 1 or 2 years were from 35 to 44 years of age. The average number of years of service for the mothers was about 6.

For the purpose of finding out whether all suitable parts of the city and county are being canvassed thoroughly for prospective homes, information about where the foster parents live is valuable. With the geographic distribution known, we can look for the reason why boarding homes in some residential parts of the city, obviously desirable locations for placing children, are scarce, while there is a concentration of homes in other parts, some less desirable.

The geographic relation of the homes to one another is worth studying in relation to the convenience of the child-welfare staff in going from home to home, as this is a factor in effective supervision of the placements.

Boarding homes concentrated

The study classifies almost 84 percent of the homes as urban. Sixteen percent were classified as rural, but only 5 percent were farm homes. Eight out of every 10 boarding homes were within the city limits of St. Paul; 15 percent were in the rural parts of Ramsey County; and the rest were outside the county. The boarding homes in St. Paul were classified according to their location in the "census tracts" (divisions of the city into tracts made by the Bureau of the Census for its own purposes), and it was found that only three of the census tracts had more than a few of the homes. One tract had 23, one had 16, and another 13, the outstanding numbers. Of the large areas of the city that had practically none of these greatly needed homes, the report states that these areas must certainly offer excellent opportunities for finding and developing homes that should remove some of the pressure on case workers who must place children for their agency.

For effective home finding and placing of children, an agency needs to know how thoroughly it is using the homes available. On the date of the

survey (August 31, 1946), 126 of the 304 homes studied were caring for fewer children than their licenses would have permitted; 164 had the exact number permitted by the license; and 12 had more. The other two homes, unlicensed, were being used for temporary care. The figures change somewhat from day to day, of course, but they were substantially the same a month later.

Note the disturbing fact that many homes were not filled to their licensed capacity although the child-welfare division is having such difficulty in placing children. Forty percent of the homes are licensed to care for one child, and 36 percent for two children, yet at the time of the study 55 percent had only one child and 14 percent had none. The reasons given by foster parents for not taking more children, although they had room for them, were analyzed, as an extremely important factor in the study. Of the 82 homes that on the date of the survey could not take more children, 19 were willing to take more later. Most of the 63 couples who were unwilling to take more children at any time than they were then boarding did not want to take them because they felt that caring for more children would be too much work, or because the children then in their homes were too much of a problem to them. Of the 19 couples who for various personal reasons could take no additional children until later, five were willing to take more children for temporary care at that time.

"Girls only"

Thirty-one of the boarding-home mothers who were willing to take more children had expressed preferences and some of these preferences made it difficult to place more children with them. Twenty-three wanted girls only; only six would take boys; one wanted to take a baby; and one a boy or girl between 3 and 7 years of age. The largest number, 14, specified a girl between 2 and 5. The preferences for children of certain ages ruled out most of the children who needed homes. To make matters more difficult for children going through upsetting experiences, the boarding-home parents indicated that they wanted children without behavior difficulties—"a nice youngster with no



This foster mother is giving a service beyond price—offering the warmth of a home to children who have lost their homes.

problems," they would say. These rigid preferences made these 31 households of little help in filling the agency's great need for boarding homes.

Another explanation of the apparent failure to use the homes to capacity is that case workers had found some homes to be better suited to a smaller number of children than the licenses permitted, but had not arranged to have the licenses changed.

The study contributes one answer to that vexing question of how to awaken the interest of potential boarding parents. Four out of every 10 couples first thought about taking children for care after hearing about the service from people who were already caring for children in this way.

Newspaper publicity, along with other formal ways of reaching out for additional homes, was for this agency far less potent than word-of-mouth information passed along by foster-home mothers and fathers to their friends, acquaintances, and fellow workers.

The survey suggests a more intensive cultivation of the already existing Foster Parents Club as a channel for the distribution of facts about the need of children for substitute homes and about the contribution that qualified couples can make to these children by opening their homes to them.

That only 18 of the 304 homes were found through newspaper stories may

mean either that this source of information is not very effective in reaching boarding parents or that this medium has not been used sufficiently well in St. Paul.

The study of St. Paul boarding homes is valuable as an example of the essential first step in any long-term program or in a campaign for an additional supply of homes. It seems clear from the report that the agencies in St. Paul that place children—public and voluntary agencies—were finding boarding homes independently of one another and were not making cooperative use of them. A long-range recommendation of the St. Paul report is that a register of boarding homes be established for the use of all local child-placing agencies. This register would serve two purposes: It would show the areas of the city in which new boarding homes should be sought, and it would permit the interchange of unused approved boarding homes by the different agencies when a home on the list of one agency is suitable for a particular child being placed by another agency. This might lead eventually to an even more thorough pooling of boarding homes for cooperative use, although the St. Paul report does not suggest this. A theme of unity has run through the experience of other cities, however, when all the child-placing agencies *did* go home hunting together.

CHIEF STATE SCHOOL OFFICERS PLAN FOR EXCEPTIONAL CHILDREN

Teach the exceptional child in a normal environment whenever possible; do not segregate such children in special schools or classes unless this is definitely necessary for educational reasons. This is one of the recommendations made in a report adopted by the National Council of Chief State School Officers. The report was prepared by the council's project committee, under the chairmanship of Dr. John S. Haitema, Chief, Division of Special Education, Michigan State Department of Public Instruction.

In making this recommendation the report points out that special services should be given to the exceptional child if he needs them; and emphasizes that no child should be denied the opportunity of enrollment in a special school or class if his educational needs are best met that way.

The report takes the point of view that every child who is educable should have the opportunity for education, and that this opportunity should include a program that is properly adjusted and reasonably adequate to meet his needs. The exceptional child's program, the committee says, should be determined upon the basis of complete analysis of the individual: His physical limitations, his psychological condition, his emotional and social adjustment, his aptitudes and interests, his educational history, and any other pertinent factors.

If every child is to have equal opportunity for attaining competence in all major areas of living—self-realization, human relationships, civic responsibility, and economic efficiency—exceptional children should be provided services that are at least equivalent to and are coextensive with those available for other children, the report says.

For certain types of exceptional children, such as the deaf, the blind, and the cerebral-palsied, educational programs for children and parents should be made available without reference to the customary entrance ages of children, in the opinion of the committee.

Since various agencies are responsible

for giving different services to exceptional children, the council urges all agencies concerned to plan together to serve the child effectively through case finding, diagnostic services, treatment, education, guidance and training, auxiliary programs (transportation, lunch, etc.), and placement and follow-up services.

State departments of education, the council maintains, should exert leadership in obtaining legislation that requires provision of adequate programs of education for exceptional children, including an educational program for children who are home-bound, hospitalized, or in sanatoria, and also in applying the compulsory school-attendance laws to such children.

The State educational authority, after considering the recommendations of appropriate advisory committees representative of school personnel and other agencies concerned with the welfare of children, should set up minimum standards for the program of services for exceptional children, according to the committee. And the children should be selected for services on the

basis of physical disability, mental deviation, and emotional disturbances, or a combination of these characteristics indicating the child's need for adaptation of the educational program or for a program that is in some respects fundamentally different from the usual one.

The report also recommends that State residential schools, except schools for children who should be in such schools for their own guidance or for the protection of themselves and of society, should gradually be replaced by programs of education that do not require institutionalization. No child should be deprived of the opportunity to live with his own parents, if his home it at least reasonably desirable. And though public day schools cannot in all cases be located where all the children may go home every day, it is possible, the report says, to provide centers geographically located so that some children may live in a foster home during the school week and be at home week-ends and holidays.

(In view of previously adopted policies by the Chief State School Officers, the present report assumes that reorganization of school districts will be encouraged so that eventually, where possible, all school districts will be adequate to provide necessary educational programs for all types of exceptional children within their areas.)

Now that Elizabeth has been receiving special services for partially sighted children, she reads better and is much happier.



The report lists eight types of exceptional children needing special educational services: The blind and partially sighted; the deaf and hard of hearing; the crippled and the cardiopathic; the epileptic; the speech defective; the mentally retarded; the socially maladjusted; and the gifted. It sets forth an estimated frequency in the school population, for each, ranging from 3.5 percent for children with speech defects to one-tenth of 1 percent for epileptic children. The committee urges that there should be no discrimination in the educational program against any type of exceptional child.

Emphasizing that different types of services and techniques are needed to meet the needs of children, the report urges that objective experimentation be done to evaluate present methods of helping exceptional children, and also newer methods. However, if evaluation brings to light a few unsatisfactory programs this should not be used as a reason for adopting either a laissez-faire or a do-nothing attitude.

CONFERENCE CALENDAR

Apr. 13-19—National Conference of Social Work. San Francisco.

Apr. 14-20—Boys' Club Week. Further information from the Boys' Clubs of America, 381 Fourth Avenue, New York 16.

Apr. 20-26—Public Health Nursing Week. Further information from the National Organization for Public Health Nursing, Inc. 1790 Broadway, New York 19.

Apr. 21-26—American Association for Health, Physical Education, and Recreation. Annual convention, Seattle, Wash.

Apr. 26-May 3—National Boys and Girls Week. Twenty-seventh annual observance. Further information from the National Boys and Girls Week Committee, 35 East Wacker Drive, Chicago 1.

May 2-3—American Council on Education. Thirtieth annual meeting, Washington.

May 4-11—Religious Book Week. Fifth annual observance. Further information from the National Conference of Christians and Jews, 381 Fourth Avenue, New York 16.

June 2-4, 1947—National Congress of Parents and Teachers. Chicago.

June 9-13—American Medical Association. Ninety-sixth annual session, Atlantic City.

IN THE NEWS

To Help Refugees and Displaced Persons

Arthur J. Altmeyer, Commissioner for Social Security in the Federal Security Agency, has been elected executive secretary of the Preparatory Commission for the International Refugee Organization.

The International Refugee Organization is to be one of the specialized agencies of the United Nations. It will deal comprehensively with problems of refugees and displaced persons, of whom there are still large numbers in central Europe.

The Preparatory Commission, the members of which represent 11 nations, including the United States, has adjourned and will meet again in Geneva April 15.

Mr. Altmeyer has gone to Europe to begin work for the Organization. Federal Security Administrator Watson B. Miller has granted him leave of absence for several months, during which William L. Mitchell, Deputy Commissioner for Social Security, will be Acting Commissioner.

Mr. Altmeyer, former chairman of the Social Security Board, became Commissioner for Social Security when the Federal Security Agency was reorganized in July 1946. He is also the United States representative on the Social Commission of the Economic and Social Council of the United Nations. Mr. Altmeyer was chairman of the United States delegation to the regional conference of American members of the International Labor Organization at Havana in 1939; chairman of the United States delegation to the First Inter-American Conference on Social Security in Chile, 1942; chairman of the United States delegation, second meeting of the Inter-American Committee on Social Security, Mexico City, 1945; and recently was elected by the General Assembly of the United Nations to serve on the United Nations staff benefit committee.

Social Statistics Supplement Available

"Juvenile-Court Statistics, 1944 and 1945," is the title of the latest Social Statistics Supplement to *The Child*, (Washington, November 1946, 12 pp.) Single copies may be had without charge by writing to the Children's Bureau. The report was prepared by I. Richard Perlman, of the Bureau's Division of Statistical Research.

Two Important Annual Reports Appear

"At the end of 34 years of service, the need for a bureau in the Federal Government that can be a focal point for the interest of citizens in children and for the development of governmental policies relating to their welfare is even clearer than in the years of effort to secure the establishment of such a bureau." With these words, L. B. Schwellenbach, Secretary of Labor, begins his recommendations for the future of the Children's Bureau in the last annual report of his Department that will include a section on the Bureau, now that the Bureau has become part of the Federal Security Agency under the President's Reorganization Plan No. 2 of 1946. (Thirty-fourth annual report of the Secretary of Labor, for the fiscal year ended June 30, 1946).

"The only way in which the United States can fulfill its central purpose—that of democratic living—and discharge its responsibilities in tomorrow's world is to make sure that every child has a fair chance to develop the qualities and capacities required for citizenship in that world."

The Secretary urges full cooperation between the various official agencies of the Federal Government whose programs affect children, and between government and citizens represented in advisory committees and voluntary associations and agencies. The National Commission on Children and Youth, and State and local commissions or councils, are promising efforts in this direction, says the report.

The Social Security Board, whose place has been taken by the Social Security Administration under the same reorganization plan that transferred the Children's Bureau to the Federal Security Agency, has issued its eleventh and last annual report. In this report the Board restates its recommendations for strengthening the social-security programs and indicates in detail the basis for improving the existing provisions in the light of more than a decade of experience in social-security administration. The Board sets forth its belief that its proposals are sound, feasible, and urgent, and that they are in accord with American traditions of free enterprise and equality of opportunity for all the people of the United States.

U. S. Department of Labor Studies Youth Employment in Two Cities

Two urban communities—Louisville, Ky., and Denver, Colo., are cooperating in a study of youth-employment problems begun early in 1947 by the Child Labor and Youth Employment Branch of the Division of Labor Standards, U. S. Department of Labor.

If a community is to help its young people achieve their best possibilities for useful citizenship and for personal success it must have facts about them, about the community, and about what is needed to achieve that aim. This study of youth employment is being made to provide a factual basis for planning to meet the employment needs of young people under 20.

Information on employment opportunities for young people is being gathered from employers, union representatives, school officials, the public employment office, and officials administering child-labor laws. Community provision for student aid, vocational counseling, and placement services are being studied; also the administration of child-labor regulations in the community, and methods of acquainting employers and the public with legal child-labor standards.

Some 500 young persons under 20 are being interviewed in each city to obtain basic data on the extent and nature of employment—and unemployment—among young people. From these young people will be learned their reasons for leaving school, the kind of work they are doing, something of their working conditions and of how they got their jobs, and what were their problems in finding satisfactory and satisfying work.

In each city a cooperating committee, made up of leaders in the community interested in youth and connected with the major agencies serving youth in the community, has been organized. In Louisville, where the interviewing of young workers began in February, such a community committee is actively cooperating in the preliminary stages of the project. It is hoped that the members of these local committees will also be interested in following up on the study by relating the findings to the community's planning for youth. Group discussions on the broad issues of the study are being planned with young people's organizations.

The Child Labor and Youth Employment Branch plans to issue a series of reports, which will be available to the general public, as the findings of the

survey are available. Special attention will be given to making these reports of maximum value to the communities visited and to all National, State, and local groups planning for youth.

Beatrice McConnell

Missouri's Code Commission Presents Final Report to the Governor

A Children's Code Commission was created by the Missouri General Assembly in 1945 to make a study of child welfare in the State, including:

"(1) the needs of children, including in particular those who are dependent, neglected, or delinquent, those who are in danger of becoming delinquent, and children otherwise requiring special care;

"(2) the laws affecting such children, including the operation and effect of existing laws, the existence of conflicting, obsolete, or otherwise undesirable laws, together with such changes in the laws and additions to them as may be needed to embody the best experience on these subjects both in relation to ameliorating the conditions of children and of preventing conditions which adversely affect the welfare of children."

The commission was made up of an executive committee, with assisting technical study committees and regional advisory committees. These 220 members represented the legislative and judicial branches of the State government; public and private welfare agencies; educational groups; churches; citizens', labor, and business organizations; and the legal and medical professions. They were selected on the basis of their "knowledge, interest, and connections with specific phases of child-welfare work." A staff was employed or borrowed, composed of an executive secretary, a legal adviser and bill drafter, a technical adviser, and a legal research expert.

These members began their work on the premise, as stated by the White House Conference on Children in a Democracy, that "All children need a home, good health, care and protection, and favorable conditions for growth. They all need education and retaining, preparation for the responsibilities of later years. They all need to acquire a personal appreciation of the spiritual and ethical values in their experience; to form standards of right living; and to have access to religious inspiration consistent with a developing philosophy of life."

As this is the first of the children's commissions in Missouri to make a comprehensive study of all the laws and programs pertaining to children and youth, its first step was to compile the present laws and the accompanying annotations necessary for their interpretation. A thorough study was made also of present conditions, facilities, programs, and needs relating to children and youth. This covered the areas of health; public and social welfare; child labor; education; care of exceptional children; State training schools; and services to children requiring court adjudication, such as adoption, establishment of paternity, guardianship, juvenile courts, and offenses against minors.

The laws and experiences of other States were investigated and the United States Children's Bureau was consulted for background.

From these exhaustive studies the commission has reported to the Governor and to the general assembly present situations, has made recommendations in regard to child health, child welfare, education, recreation, and services for children requiring court action, and has prepared drafts of bills.

Because social and economic changes take place at an accelerated rate, this commission has recommended, also, that a children's code commission be created by each successive general assembly, so that children and youth shall be provided with the protection that conditions require.

Copies of this report were presented to other State planning commissions for children and youth. Those States that are continuing or are proposing a review of governmental services for children will find the Report of the Missouri Children's Code Commission a useful handbook.

Stella Scurlock.

Two Conferences Held— Reports Next Month

A small group of specialists working with children with cerebral palsy met at the Children's Bureau March 26-28, as a step in planning a major effort by the Bureau and State crippled children's agencies to get help to these children.

A National Conference on the Blind Preschool Child was held at New York, March 13-15, by the American Foundation for the Blind, Inc.

A report on each of these conferences will be published in the May issue of *The Child*.

What Rheumatic Fever May Mean to a Child

(Continued from page 169)

For example, a member of my staff told me recently that she had thought she understood the situation of a certain schoolgirl who had rheumatic fever. Then she was obliged to visit the girl's home. To her amazement, she found the home set on top of a high hill. Though young, healthy, and light in weight, the case worker found herself breathless from the walk up the hill. Then she counted over 100 steps that she had to climb from the sidewalk to the front door. After the visit she decided to traverse the route that the girl followed between home and school. After going down and up several hills, she realized that some radical change would have to be made in the environment of the patient, whose primary problem the worker had thought from office interviews to be entirely psychological.

Staff should understand children

When children are placed in sanatoria or other institutions, or in foster homes, these should be staffed with personnel who understand children and their needs and who know the nature of rheumatic fever and its demands.

Wherever the child has his prolonged rest, whether at home, in a hospital, a sanatorium, or a foster home, there should be provision for education, recreation, and occupational therapy. The extent of the activities allowed the child should, of course, be based on medical recommendations.

In order to prevent invalidism and inferiority feelings, and to promote economic independence in adulthood for those whose physical condition permits, it is of the utmost importance that vocational guidance and training be provided so that the child will be prepared for a life that will yield him the maximum of satisfaction.

Thus briefly sketched are some of the emotional and social needs of the child ill with rheumatic fever. Medical care alone is inadequate, and is economically wasteful unless at each step there is study and active planning to meet the child's emotional and social needs.

Adapted from a more comprehensive paper by Miss Cohen.

Reprints available in about 5 weeks.

Toward Peace Through Understanding

(Continued from page 165)

gate the possibility of setting up international study centers. And it will study textbooks with a view to improving them with regard to international understanding.

The UNESCO-wide project on international understanding for 1947 includes five general areas: (1) Education for international understanding in primary and secondary schools and in institutions of higher learning; (2) International-relations clubs; (3) Teachers' seminars; (4) International study centers; (5) Analysis and revision of textbooks.

"A long-term, world-scale attack on ignorance" is the way UNESCO describes its project on Fundamental Education. It is a many-sided undertaking, including primary education; work with adult illiterates; and education for health, for economic and cultural development, and for international understanding and citizenship.

A few examples of the work that is planned within the program sections of UNESCO are:

Under Social Science, UNESCO will study the possibility of an International Center for Home and Community Planning. It will promote and stimulate the research work already being done into tensions conducive to war.

Under Philosophy and Humanistic studies, philosophers will study the underlying philosophic problems of our times, in an effort to find common ground for understanding.

Among the projects planned under Arts and Letters are collection of information on all aspects of artistic activities and facilitation of international exchange of artists.

One of the tasks listed for the section on Libraries is to begin work on the proposed Public Libraries Conference to be held in 1948.

The Natural-Science section has a long-time plan for creation of an International Institute of Hylea, the jungle area of the vast area of the Amazon Basin, for the scientific exploration of that region.

In the third large classification of UNESCO's program, "continuing ac-

tivities," will be such projects as exchange of information on children, including methods of caring for handicapped children, methods of dealing with juvenile delinquency, and work for mentally retarded children. UNESCO will support the work of various international associations. It will prepare a world register of scientists. It will collate UNESCO's work in the field of mass communication with that of the United Nations and the other specialized agencies of the United Nations. These are only a few of the many types of continuing projects that will go on from year to year within the various sections.

Only a small proportion of the activities are expected to be carried through UNESCO's own small staff. The main work of the Organization is to stimulate, encourage, and assist other agencies in these activities. It will work closely with the Economic and Social Council of the United Nations and with the other specialized agencies, such as the Food and Agriculture Organization and the World Health Organization.

UNESCO points the way toward world understanding. But we must not expect too much, too soon.

Alfred and Judy, on our April cover, are sightseeing during their Easter vacation; their school is closed for a week. Many thousands of children in Europe and Asia have no schools to go to—and no books, no paper, no pencils. But a United Nations agency, UNESCO, described in this issue of *The Child*, is encouraging efforts by voluntary agencies to reconstruct the educational systems in the war-devastated countries. Photograph by Rebecca Snyder.

Other credits:

Page 163, British official photograph.

Page 164, Signal Corps photograph.

Page 165, photograph by UNRRA.

Page 167: Left, Library of Congress photograph (taken for Farm Security Administration); right, photograph by Frank H. Ubbhaus.

Page 169: Left, photograph by Wisconsin State Department of Public Instruction, Bureau for Handicapped Children; right, photograph by Philip Bonn for Children's Bureau.

Pages 171 and 172, Library of Congress photographs, by Russell Lee for Farm Security Administration.

KEEP OUR CHILDREN SAFE

Accidents now kill more children in the United States than any single disease. This year the President's May Day Child Health Day proclamation reminds us of this and calls on us to protect our children from needless injury and suffering.

To give effect to the proclamation, a Nation-wide educational campaign is to be conducted throughout the week of April 27. This is planned to rouse parents to the need for precautions against accidents in the home.

During that week, the Children's Bureau, in cooperation with the National Conference on Home Safety, will try to bring home to parents the facts about accidents.

The main fact is that accidents take a yearly toll of almost 20,000 boys and girls under 20 years of age, and that the majority of these deaths are preventable. And in addition, thousands of children are crippled and maimed by accidents that could have been avoided if elementary precautions had been taken.

Death rates for accidents are the highest during the first year of life; they are lower in the preschool age, and lowest in the elementary-school age. They rise again in adolescence when young people go out to work. Among children be-

tween 1 and 4, accidents are one of the leading causes of death.

Smothering is the main cause of accidental death in infancy. By far the most important cause of accidental death in older children is automobile accidents. Drowning, burns, injuries by firearms, and injuries by falls follow in that order.

Emphasis in the May Day campaign is to be given to the prevention of home accidents, for a high proportion of these fatal accidents to children take place in the home, and it is largely the younger children who are the victims.

In 1944, 6,000 children under 5 years of age died as the result of injuries sustained in the home.

Home accidents resulting in death make up a smaller proportion of the total in the school-age group: deaths from motor-vehicle accidents and from drowning account for greater numbers. Even so, the number of home accidents that cause death is large—an estimated 2,000 such deaths a year in the 5- to 14-year group.

For every child who dies from a serious home accident, many other children suffer severe injury, even though they do not die. Thousands of these children year in and year out are treated under the Federal-State crippled

children's programs, which are financed with funds granted to the States by the Bureau under the Social Security Act. In January 1945, 7,500 children who were crippled because of severe burns were known to the State crippled children's agencies, along with 21,000 other young victims of accidents of one sort or another.

Placing the emphasis on accidents, as we are doing this time, is somewhat of a departure from the traditional observance of May Day Child Health Day, for accident prevention is not generally thought of as part of a child-health program.

The facts, though, show that public-health groups, the schools, parent organizations, and others need to do a great deal of work in helping to prevent accidents to children.

We must all work together—parents, teachers, and all persons interested in children, as in other years, on May Day, we have joined in working for other phases of children's well-being. Let us here highly resolve to keep our children safe.

Martha M. Eliot
 MARTHA M. ELIOT, M. D.,
 Associate Chief,
 U. S. Children's Bureau.

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THE
CHILD

MAY 1947



WHAT DO CHILD-WELFARE SERVICES OFFER?

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TODAY hundreds of thousands of children are living under conditions that deprive them of the opportunities and privileges contributing to good citizenship.

Can ways be found, through social services, to meet the problems of these children, who need attention beyond that given by their parents, teachers, Sunday-school teachers, family physicians, and the other normal contacts in the lives of ordinary children?

Let us seek the answer to this question by asking five more: (1) Who are the children that need social services? (2) Whose responsibility is it to meet these needs? (3) What kind of services must be provided in the child's community? (4) How do State responsibilities mesh with local services in a complete program for the individual child? (5) What does it take to get social services to children?

Who are the children that need social services?

We are inclined to think of children in twos or threes, as members of family groups. We often know little of the number and significance of children's problems in relation to the total picture of the life of the Nation. But nearly one-third of our population are children under 18 years of age.

Many children are homeless because their parents have died, or have deserted them, or are separated. Many more are in homes that fail to meet their needs because their fathers and mothers are unable to fulfill the normal responsibilities of parenthood because



they are mentally limited, emotionally immature, or mentally ill.

Some of these children don't wait for social agencies to recognize their needs and help them. They run away, hoping to escape from their unhappiness.

The more fortunate of these children of broken or breaking homes are the ones that parents or others bring to a social agency for care and placement in a substitute home. For some other children the State takes over their care to protect them from moral or physical harm. But many children do not have this help and protection. They are in jails, or in overcrowded institutions, or in unsupervised, unlicensed foster homes. Or they are stranded, without any form of shelter, and are subject to every kind of exploitation.

And more and more children have difficulties that require special attention in their own homes.

These mentally or physically handicapped children are among those greatly in need of care. The child and his parents too will need special help if he is to remain at home, make normal adjustments within his limitations, and get satisfactions from his successes.

Then there are other children, who are under pressure of economic want or of social or racial discrimination. These include the children of minority

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groups. They also include children of unmarried mothers, and many of these mothers are hardly more than children themselves. Less dramatic and less clearly recognized are the needs of children with regard to legal guardianship.

Many sources tell us of the needs of children. Yet their needs are not yet being fulfilled, in spite of the fact that we know these needs and how urgent they are. Our job is to meet these children's needs, which brings us to the second question:

Whose responsibility is it to meet these needs?

There was a time when we could not have answered that question—when children had no rights; and when adult responsibility for children was at best inconsistent. That day is past. Today we have firmly established the responsibility of the whole group—the public—for everyone when individual responsibility fails.

A major part of the State's responsibility to safeguard the welfare of its citizens is to assure necessary care and protection to all children. And counties, townships, and municipalities share in this responsibility through power delegated by the State.

It is a public responsibility to be certain that necessary social services are available for all children who need them, regardless of residence, economic status, race, religion, or any condition other than need for services. We must face the full meaning of "Our concern every child."

"Every child" means more than "children of selected races and communities," and more than "children whose needs can be fulfilled by existing facilities." It means *every* child, regardless of the nature of his problems or of individual or social prejudices.

If the services are to be available to every child, they must be available in the locality where he lives. They must be known throughout the community and must be accessible to all families.

If the public welfare program is State-administered, there must be sufficient units to provide State-wide coverage. When programs are locally administered, the State must assure the operation of the basic child-welfare program in every locality. There are more

rural children in proportion to adults. But the average family income and the per capita income are lower in rural than in urban areas. And a majority of our children have the benefit of only a minority of the resources of our country, including resources for health, education, recreation, and social service.

However, acceptance of public responsibility in either urban or rural areas does not mean that all services must be public. The private agency has the right to define the scope of its service in accordance with community needs. We must never impose limitations upon the experimental creative genius of private effort. Volunteer agencies can push the goals beyond present hopes.

Regardless, however, of the accident of strong or of ineffective leadership in the community where a child lives, he must be assured minimum standards of service. We agree that the State is not obligated to provide all services, nor to duplicate those now meeting the needs of children. But it is a public responsibility to see that social services reach all children needing them.

What kind of services must be provided in the child's community?

Services can be classified into two broad groups: (1) The personal services directed toward helping to meet a child's need; (2) the broad services that reach behind existing problems to find causes, prevent the same problem from occurring for other children, and build strong communities.

The most effective service is one that relieves a difficulty before it becomes a serious problem. The case worker is apt to see only children whose needs have become acute enough to demand urgent action. If the children are to be reached in time to receive the most effective service, the available services must be known and understood by those who are in a position to recognize incipient problems. For the most part symptoms of difficulties appear in group relationships: so parents, teachers, group leaders, and others who see children in action usually see problems first. We must help them understand child-welfare programs so they will ask for service readily. People may know the service is there; we must help them use it.

Child-welfare programs include services to children in their own homes: (1) When the parents see the need for help as the child's problem, not theirs; (2) when the agency goes into a family to protect the child. The focus is the child—the total child as an individual in a family setting. The agency does not enter the family primarily because of the parents' behavior or needs, even though its service may help to meet those needs and to bring about changed behavior.

Comprehensive social services for all people are not available. Therefore the public child-welfare agency is giving service in some cases that may be appropriate to family service. As services for all people are provided, agency responsibility for these situations will be redefined. However, many of them will remain in the children's field because the recognized problems are approached through the child.

What then are some of the situations in which children need social service?

Many children suffer from defective vision, deafness, speech difficulties, crippling conditions, mental retardation, or illness. The child and his parents need help in understanding his

limitation and obtaining treatment and training. Behavior problems that result from emotional factors, less apparent but equally handicapping, also need special attention that social services make possible. Often these conditions pose problems beyond the normal range of parental understanding and experience. They are baffling to families at all economic levels, in all races, in all locations. But skilled social services often make it possible to help the child in his family setting and prevent the added problems arising from placement away from his own home.

Health services, education, recreation—all resources that can help diagnose and meet the child's needs—must be brought to bear upon his problem. Case-work service is the thread that weaves through the complicated strands of these programs and ties them into a pattern of unified service for the child and his family.

If the child's problems arise not from his individual handicaps, but from pressures of family and community disorganization, his need may be met by strengthening the family or supplementing its efforts. For example, when a mother is ill, or both parents are ab-

Social services should be available to any child that needs them, regardless of residence, economic status, race, or religion.



sent, homemaker service may keep children from being neglected or placed away from their homes. Counseling service may help a mother who is seeking employment, because exploration of ways of meeting the family needs may make it unnecessary for her to go out to work. Or information about facilities for day care, and guidance in using them, may help relieve the unfavorable effect of the mother's absence upon the children.

When children are abused, exploited, or neglected to the extent that their welfare is jeopardized, protective service is required. The child-welfare worker must know how far the rights of parents to care for their children in their own way will be endorsed by the community. If social service is not already being provided, it must be initiated by the agency. And it must be sustained until the condition improves or the case is brought to court for adjudication.

Placement of children also makes up a large part of these direct personal services to meet identified needs. Children are placed in foster care for numerous reasons and in countless ways—some based on skill, some on chance. But all children in foster care need the help of skilled social services. The type

of placement should be determined by competent diagnosis of the child's needs. Social services must meet the needs of children in all kinds of foster settings. For a child not known to a children's agency at the time he is placed emergency shelter care may be needed. Need for such care may result from sudden illness of the mother, extreme neglect, or lack of social services to help the child in his own home.

Social services for children in foster care cannot be given if appropriate facilities for that care are not provided. The same facility cannot combine long-time and temporary care, or detention and temporary care. Each facility must be geared to meet specific purposes. Otherwise plans for treatment are confused, and adjustments of children disrupted.

Even though children in detention care are under the jurisdiction of the court, social service should be available as for any child in foster care. Case-work service is helpful, not only to the child but to the court and need not be confused with judicial authority and action.

The facilities should include a variety of foster homes and group-care agen-

cies so as to individualize the adjustment of each child.

We cannot think the saturation point of foster homes has been reached when we have not put our best skills into home finding, allowed time for it, or explored fully the possibilities of paying for service of foster parents.

To establish and maintain group-care facilities, we must encourage careful selection of personnel, adequate pay, and good working conditions. But every kind of group-care facility need not be set up in every locality. Some, like institutions for physically or mentally handicapped children, can be provided better on a State-wide or district basis. Others may be seldom needed so that out-of-State facilities will be acceptable.

Foster-care programs must be financed adequately to assure the children security. The time and effort child-welfare workers have put into soliciting funds to support children even inadequately in foster care are evidence of the serious gaps that exist.

This brings us to the broad planning and preventive services that make up the second part of the services we must provide. Interest in community resources extends beyond the identified needs of children in their own homes or in foster care. The services that are specific in relation to individual children become broad and inclusive in relation to community planning.

Community patterns differ in organization of services and facilities, in agreements between agencies, and in practices. Into that framework the social services for children must fit. Their content cannot be detached from community developments. They must not, however, be merely part of the community stream. Persons carrying responsibility for social services for children must help to direct the course of the stream and to harness its power in behalf of children.

The child-welfare worker sees the bad spots of social disorganization and knows the problems of children whose needs are not being met. In addition to her first-hand knowledge of problem areas, the child-welfare worker brings to community planning her understanding of facilities and services needed. She must establish effective relationships with a wide variety of agencies

Symptoms of difficulties often appear in group relationships; parents, teachers, group leaders usually see children's problems first.



and individuals. She must be active in fostering leadership in group programs for children. She must help strengthen whatever meets the needs of children.

But before it appears that the child-welfare worker has the entire job to do, let us remind ourselves of some of the things she does not do. She does not take on the job of recreational leader, public-health nurse, or judge. She does not undertake group work or psychiatric techniques or psychological services. She does not run the community fund-raising campaign. She does not operate the group-care facility nor act as foster mother, regardless of the need. The core of the child-welfare worker's job is individual service to children, but she participates actively in community planning through her knowledge of children's needs and of appropriate ways to meet them. She makes certain that children are not forgotten.

Interpreting children's needs and social services for them is a constant part of the child-welfare worker's life. Every contact she makes, even the simplest, is a kind of interpretation.

Coordination of social services for children with programs of other agencies is basic to serving the child. The child-welfare worker has a primary responsibility in this, for it is her job to keep children's rights in view.

As we look at the variety and complexity of the services that must be provided in the child's community, we cannot but feel a keen sense of obligation to the child-welfare worker who takes on this job. Aware of that obligation, let us look at the fourth question:

How do State responsibilities mesh with local services in a complete program for the individual child?

If the program is State-administered, the State will provide all the services already discussed, in addition to those peculiar to its position. In a locally administered program the State may provide facilities or services that cannot be carried by local units, such as specialized institutional programs for physically or mentally handicapped children, psychiatric and psychological services, and special group-work consultation.

In the role of leader and protector the State has responsibility for the licensing and supervision of children's agencies, institutions, and foster homes,



There are about 43 million children under 18 years of age in the United States—nearly one-third of our population.

Both minimum standards and desirable goals should be established. State service should extend beyond routine inspection to supervision as an educational process. State services should help improve standards and foster dynamic relations between agencies and with communities.

For agencies that do not meet minimum standards courage is required in helping the agency achieve that minimum or discontinue its program. Perpetual provisional licenses for substandard agencies do not fulfill the responsibility to protect children.

In establishing new agencies, State responsibility ideally includes (1) determining the need for the facility; (2) passing upon the application for incorporation; (3) help in coordinating the new program with the existing one.

The State may delegate responsibility to local child-placing agencies for studying and recommending foster homes for licenses, but it keeps the ultimate responsibility.

Interstate placements are a concern of the State department that licenses the child-placing agency and of the similar department in the State where the child is placed. The interest of both States should be in the protection

of the child and not in security bonds or legal penalties that may be imposed for nonconformity with laws and regulations. Unplanned, unsupervised long-distance placements too often have resulted in need for emergency care.

State review is also helpful in adoptions, even when the placement has been made by a licensed children's agency. As a party to all adoptions, the State welfare department assures representation of the child's interest.

Another responsibility of the State is setting and maintaining standards of social services to children. This requires providing specialized consultant service or supervision for all local public agencies on a regular, continuous basis. The general child-welfare consultants help improve the quality of case-work services, stimulate effective community planning, and make available State and other facilities. Consultant service from other specialists on the State staff should also be available to local agencies. These experts will include child-welfare consultants working in such fields as adoptions or institutional programs, and also specialists such as the group-work consultant, the psychologist, the legal adviser, the nutritionist, and the research expert.

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YOUNGER WORKERS MOST LIABLE TO INJURY

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CHILD WORKERS are more likely to be injured on the job than adult workers, and they are far more likely to suffer injuries that result in a lifelong handicap. That is what the Department of Labor found recently in a Nation-wide sample survey of selected manufacturing industries.

According to preliminary data compiled from this survey, the frequency rate of disabling injuries (that is, the number of disabling injuries per million man-hours of employment) was 22.9 for minors under 18 years of age; this was 46 percent higher than the corresponding frequency rate for workers 18 and over—15.7.

ment impairments, and all temporary disabilities that resulted in an inability to work that extends beyond that day—or shift—on which the injury occurred. "Permanent impairments" include only those nonfatal injuries that permanently disabled the worker either totally or partially.

The special survey of industrial injuries in manufacturing industries from which these rates were computed was a joint project of the Child Labor and Youth Employment Branch of the Division of Labor Standards and the Bureau of Labor Statistics. It covered one quarter of the year 1945 for each industry. The information was collected in connection with the Bureau's regular quarterly collection of monthly data on injuries from selected establishments in a wide variety of manufacturing indus-

teries, under the child-labor provisions of the Fair Labor Standards Act, the occupations particularly hazardous to minors.

The survey included all types of workers in the reporting establishments, regardless of occupation. Office, clerical, and sales workers were covered, as well as those employed on production, in maintenance, and in transportation.

The high frequency rate of industrial injuries found among minors under 18 emphasizes the need for State and community action to safeguard young people from industrial hazards.

Legislative protection can be given to young workers in three ways:

(1) Through extension of the 16-year minimum-age standard to all manufacturing industries in States where lower standards prevail.

(2) Through setting an 18-year minimum-age standard for employment in industries and occupations known to be especially hazardous for minors, with employment certificates required for minors up to 18 years of age and limitations on night work and on maximum working hours for minors under 18.

(3) Through payment of additional compensation under State workmen's compensation laws in the case of minors injured while illegally employed. This method, although only indirectly preventive, makes possible a relatively generous restitution to children injured through society's failure to protect them.

But putting laws on the statute books is not enough by itself. The development and carrying out of desirable standards for youth employment calls for interest on the part of the entire community, and for active cooperation by parents, schools, counseling and placement services, employers, labor unions, and youth-serving agencies.

Many industrial injuries to youth could be prevented not only by better laws and by better law enforcement, but by better placement of young workers, by better training in safe practices, and by better supervision on the job, especially of the immature and less experienced worker.



Work on bakery machinery is extremely dangerous for a 17-year-old boy like Charles, who is likely to put safety last.

For permanent impairments, the frequency rate was nearly twice as high for minors under 18 years as for those 18 and over—1.1 for the younger workers and 0.6 for the older ones.

"Disabling injuries," as defined in this survey, include all fatalities, all perma-

nent impairments, including iron and steel products, textiles, paper and allied products, food products, leather goods, chemical products, and others.

The Child Labor and Youth Employment Branch is studying the data on individual industry classifications to de-



Joe has been living with his adopted parents for some time. But the final adoption decree cannot be issued in his State until a year has passed and the child-welfare division of the public welfare department is satisfied that the adoption is suitable.

the agency should have the right to appear at the hearings.

4. Court hearings should be closed to the public and the confidential nature of the records should be assured.

5. A period of residence in the adoption home, preferably one year, should be required prior to issuance of the final adoption decree, so that the suitability of the adoption may be determined.

Through these and other safeguards in adoption and related matters babies would be taken out of the "black market." Their chances of getting a good home would be greatly increased, and, as a corollary, good foster parents would have a better chance than they now have to get a baby to adopt. Those who are willing to go through authorized channels are today losing out, in all too many instances, to those who bypass the procedure set up for the protection of all three parties concerned in the transfer of custody.

Along with a tightening of the laws must come an improvement and expansion of those social services that are involved in the matter. These include, first of all, services for the unmarried mother and her child, for unless the social agency is able to offer such a mother help of the kind she needs she will seek another way out of her difficulty. Her baby will be "given away" as thousands of babies are now being "given away" without anyone's taking official responsibility for the kind of home he is getting. Many of these children are not adopted by those taking them, but "given away" again with little regard for the fitness of those taking them.

In addition to getting more services and better services for the unmarried mother and her baby child-placing agencies must be adequately staffed so that they can give adoptive parents and the courts the kind of help they want and are willing to accept.

Adoption proceedings are initiated for some 50,000 children each year, according to estimates. Recent statistics for 15 States show that approximately three-fifths of the children being adopted were born out of wedlock. Most of those born in wedlock were children whose homes had been broken by the death of one parent, or both, or by divorce, desertion, or separation.

R.E.C.

STATES TIGHTEN ADOPTION LAWS

AT LEAST 20 State legislatures in session during the 1947 legislative year have been considering extensive changes in their adoption laws and related procedures. This estimate of the number of States considering such legislation is based upon requests received in the Children's Bureau for its advice on bills being drafted in line with the Bureau's recommendations on adoption laws.

Changes are contemplated not only in such laws, but also in laws affecting relinquishment of parental rights, licensing of child-placing services, and determination of guardianship.

A number of States have also been considering changes in birth-registration procedures in order to protect the child born out of wedlock. More and more States are adopting a simple "birth card," which has on it only the name of the person, the place and date of birth, and sex. The complete record, on which the illegitimacy item appears, is safeguarded and is accessible only to those who have a direct interest in the matter.

Only about a fourth of the States now have the kind of adoption legislation that the Children's Bureau considers necessary for adequate protection of the child and the rights of the natural parents and the adoptive parents.

The Bureau's main recommendations have been embodied in the legislation suggested by the Council of State Governments for 1947. These recommendations are:

1. Adoption proceedings should be held before a court accustomed or qualified [otherwise] to handle children's cases, in the locality or State where the petitioners for adoption reside.

2. Consent to adoption should be obtained from the natural parents, or, if their parental rights have been legally relinquished or terminated, or if there is no parent, from the person or agency legally authorized to consent to the adoption.

3. The court in every proposed child adoption should have the benefit of study and recommendations by the State welfare department, or an agency designated by it. The department or

Stop Sniping at Parents

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THE LAST 20 YEARS have witnessed a thoughtless, unwarranted, and destructive wave of criticism against parents. In the beginning such criticism served the useful purpose of demonstrating that the source of a child's misbehavior does not always lie within the child. Unfortunately it has led to a fault-finding campaign that is as futile as the previous campaign against "little sinners." It seems that every amateur mental hygienist has come to the same profound conclusion, that parents have an effect upon their children.

How some people reason

The hasty thinking of some continues—

"If children are delinquent it follows that their parents have been a poor influence. So, really, after all, it is the *parents* who are delinquent. So, if the parents are to blame, let's punish the parents. It might even be an idea to make them attend classes for delinquent parents for all the community to behold their shame. Who will teach these classes? Oh, really we can't afford to hire professionally trained personnel. Of course, we can get loads of volunteers who would be willing to tell parents how to be *good* parents."

This writer, for one, refuses to believe that the intelligent people of our country can fall for this utter nonsense. This writer refuses to believe that the people who really care about building a decent community and decent citizens can be content merely to fix the blame and go back to a state of blissful serenity, under the illusion that the job is done.

The most serious fallacy found in the thinking of these zealous critics lies in the assumption that parents are aware of their own shortcomings and deliberately plan to misguide and mistreat children. Common sense tells us that this is a false assumption. From

the cases seen in child-guidance clinics, it has been observed that the type of parental guidance contributing to a child's poor adjustment is largely unintentional and unwitting.

Everybody is familiar with the parent who is overly ambitious to have his child succeed in art, music, or some other endeavor. Many a child has become sullen and destructive because his parents have quietly but firmly led him into such "wholesome" pursuits, in spite of his lack of interest and of ability. Many parents who come to guidance agencies regarding their child's difficult behavior begin to realize after a while that they have contributed to the development of the problem through certain personality trends of which they were totally unaware.

But hasn't every such parent been told by friends and relatives about these tendencies to control and to dominate? To be sure, many have been told, and some have been able to change their

attitudes. But many do not change because the change is more painful than the problem.

For example, take Mrs. L., the mother of 9-year-old Tommy, who dawdled over his food. This mother was advised by a friend to "place the food on the table. If Tommy is hungry, he will eat. If he does not eat, take the food away."

Mrs. L. was accustomed to hovering over Tommy, engineering each mouthful. As far as the child was concerned, the advice given might have been beneficial. But did the well-intentioned friend realize that the mother had an unconscious fear of the child's growing up? In the mother's own life history, there had been a pattern of people's leaving her. Both her parents had died by the time she was 8, and she was left in the care of older sisters until she married.

Mrs. L. was fairly happy with her husband, but she tended to thwart the child's thrusts towards independence because of the unconscious fear that his growing up would eventually lead to her "being deserted"—an old, painful experience.

A person who casually advises Mrs. L. to allow her child to develop habits leading towards independence fails

We should try to see fathers and mothers not only as parents, but also as men and women with problems of their own.



completely to take into consideration why and how the mother's attitudes developed. What is more, such advice, if taken, may make matters worse, for the mother may begin to substitute secret devices for infantilizing the child so as to avoid criticism. Obviously, parents like Mrs. L. need professional help—not criticism, nor blame.

Parents were once children

Those who still insist on fixing blame for juvenile delinquency should make doubly sure that the blame is falling upon the persons who are truly responsible.

Let us take the case of Johnny D., 10 years of age, who has been picked up by the police 12 times for petty thievery and destruction of public property. His father has always been extremely severe in his punishment of the boy. He openly dislikes the boy and tolerates his presence only when Johnny either is quiet or is doing something useful at home. He is quick to criticize, and never praises the boy. The mother is weak, self-effacing, and fears disagreement with the father, who has a violent temper. She does not display any affection toward John because her parents taught her that too much demonstration of love spoils children.

Thus far, the picture is clear. These parents by any standards are inadequate

parents. But they were once children too! Mrs. D. was unwanted and unloved. Mr. D. was raised by parents who had to struggle so hard to eke out a mere subsistence that all he ever knew all through childhood was hard work and thankless tasks. He had never seen a toy and never received approval from his parents. He heard from his father, though, when the corn was not planted in a perfectly straight row! What was there in this man's heritage which would enable him to enjoy the company of children? Yet the community is perfectly willing to render its diagnosis, "abusive father."

Do we mean, then, that the true blame for Johnny's delinquency goes back to the father's father? And to the mother's mother? Why not to Adam and Eve?

That is precisely the point; it is fruitless to spend our time fixing blame. Let us rather see Johnny's parents as individuals who are in need of sympathetic guidance given by those who are competent through professional training and experience to offer such guidance. The problem of helping Johnny's mother and father to become more adequate parents can never be accomplished by the "holier than thou" lecture. Well-intentioned amateur advisers merely cause resentment and may fix harmful attitudes permanently. A

father such as Johnny's, who had to struggle against overwhelming odds, feels that he is doing the best he can to maintain his family. He is already embittered about life and is sensitive to his failures; this makes it all the more necessary for him to bluster and act tough.

It is essential, therefore, to see and understand the parent as a person who is in need of help with his own problems. It is vitally important that we understand the parent of a poorly adjusted child as a person who has had more than his share of difficulties and frustrations. He doesn't desire words of advice, since he probably has tried and discarded many conflicting and confusing remedies. Too often the neighbor who has unlimited advice to offer closes the door of her home to Johnny lest he contaminate her Henry. Yet Henry's friendship could be of more help to John than her words of advice.

Not wanted in neighborhood

The writer, and undoubtedly the reader also, has witnessed the pathetic spectacle of the "undesirable" youngster who goes from house to house in quest of human companionship and learns that there is a neighborhood boycott against him. What choice is there but to seek the company of other outcasts, who invariably take a keen delight in getting back at "acceptable" society?

The task of parenthood has never been easy. It is even more difficult during a period of industrial unrest, acute housing shortage and complex postwar readjustments, because parents reflect such strains in family life. And since children invariably reflect parental strains, it is logical to expect an increase in juvenile behavior and personality disorders.

Thus, no matter how we twist or turn, the inevitable conclusion is that maladjustment and delinquency are responsibilities of the entire community. Our goal must be wholesome physical and social development for *all* children and a sound program of professional help for those children who are in conflict with the standards set by society.

One of the primary obligations of the community is to set up adequate social agencies which are so well equipped with professionally trained social case workers, psychologists, and psychia-

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Children reflect parental strains, and Rosamond is affected by her mother's feelings, even though she doesn't understand them.



FOR THE BLIND CHILD'S FUTURE

BLINDNESS of itself does not necessarily retard a child seriously, but lack of affection and of security in his early life may result in personality defects that are far more injurious to the blind child than his lack of sight.

This idea was emphasized at the National Conference on the Blind Preschool Child, which met at New York March 13-15 under the sponsorship of the American Foundation for the Blind.

About 200 workers in various fields—education, nursing, child development, social work, psychology, and ophthalmology—came to this conference to exchange experiences in fulfilling the needs of babies and little children who are blind or nearly blind. Workers came from a number of States, and from Brazil, Canada, China, Panama, Paraguay, and South Africa.

The conference was the first of its kind, for it is only within the past few years that the majority of persons working with blind children have begun to realize that the earliest years of life—long before the child is old enough to go to school—are the critical ones in determining his future.

The first day of the conference was devoted to social-work aspects of the problem of the preschool blind child. Dr. Elise Martens, chief, exceptional children and youth, U. S. Office of Education, was chairman at the morning session, and George F. Meyer, executive director, New Jersey State Commission for the Blind, in the afternoon.

On the second day, educational aspects were taken up. The morning chairman was Dr. Kathryn E. Maxfield, director, Lighthouse Guidance Service; the afternoon chairman, Dr. Gabriel Farrell, director, Massachusetts School for the Blind.

Medical aspects were reported on in a single session on the third day: Conrad Berens, M. D., executive surgeon in ophthalmology, New York Eye and Ear Infirmary, was chairman; and Willis S. Knighton, M. D., surgeon at the same institution, cochairman.

Child needs to feel secure

A child who lacks motherly care and affection during the early years of his

life will have personality defects that later educational efforts can hardly banish, Lauretta Bender, M. D., associate professor of psychiatry, New York University, told the conference. If he is placed in an institution or is changed around from foster home to foster home, or if his mother is not affectionate and understanding in her attitude toward him, continued Dr. Bender, the child will be deprived of the secure feeling that he needs in this critical period of his development. A child with a physical disability such as blindness, she said, needs such care and affection even more than do other children. And the personality difficulties caused by lack of affection in his early years may cause him more unhappiness than his blindness.

Parents respond in various ways to the shock of learning that their baby is blind, said Eunice W. Wilson, director of social service, Massachusetts Eye and Ear Infirmary. Their reactions range from hysterical outbursts to emotional paralysis. Some refuse to believe the child is blind, and seek the opinion of one specialist after another.

The medical-social worker tries to help the mother to keep from developing an attitude toward the child that may become harmful to their relations, for she knows that the blind child, like the seeing child, reacts to the mother's feelings. It is possible, when the child is still very young, to help the mother to modify her tendency to reject him or overprotect him or both.

If the case worker can do this, giving the mother specific suggestions on training the child and relieving her from family strains that arise in connection with him, the mother may gradually come to accept the child as a personality from whom she receives—and to whom she gives—affection. And the child will benefit accordingly.

Some parents cannot face reality

Some mothers—and occasionally fathers—seem unable to deal with the fact that their child is blind, and these need help from a psychiatrist, Mrs. Wilson said.

All community services that are useful to the seeing child should also be available to the blind child, said Ruth

Butler, medical-social worker, Massachusetts Eye and Ear Infirmary. The blind child should have access to convalescent care, foster-home care, child-guidance clinics, and nursery-school programs. Also, she said, the blind child finds his greatest sense of security in his own home, in his place in the family group, rather than in an institution.

Frances E. Marshall, social worker, Perkins Institution and Massachusetts School for the Blind, told of a summer nursery-school project for helping a group of mothers of blind babies with their problems. About a dozen mothers, all of whom had babies with visual handicaps were brought together for about 2 weeks. The project was carried out cooperatively by Perkins Institution, where the summer nursery school was held, and the social-service department of the Massachusetts Eye and Ear Infirmary, with financial help from a foundation. The nursery school also was part of a research program for study of the cause of these children's blindness.

Group experience valuable

The mothers had many things in common, said Miss Marshall. For example, each of the babies was prematurely born, and had been separated from his mother for a considerable time while he was cared for in an incubator. Some mothers had feelings of guilt or inferiority about having a blind child, and some worried over the baby's mental development. Others disliked being conspicuous when taking the baby out in public. Some had well-meaning in-laws who pampered the child.

The mothers liked belonging to a group, with common experiences, and they helped each other in working out their difficulties.

Although the project was successful in showing that group work, in support of individual work, was effective in dealing with the problems of mothers of blind children, Miss Marshall said that this type of therapy had drawbacks. Many mothers who most needed this help could not leave their families for any length of time. Some made comparisons between themselves and other mothers, which left them overoptimistic; others found themselves more anxious than before. And some felt a

let-down when they returned home. Also it was impossible to give adequate follow-up on account of distance. Besides, Miss Marshall said, a school for the blind may not be as acceptable a place for a nursery school of this type as an ordinary school.

In 1947, instead of the summer-school project, Perkins Institution expects to offer 2-day institutes in various localities, Miss Marshall announced. In each area a local advisory committee will be formed, composed of a worker from the division of the blind, an ophthalmologist, a pediatrician, and social workers. The program is planned primarily for the mothers of blind preschool children, continued Miss Marshall, but it is hoped that social workers from State and local agencies for the blind and other workers will take part.

Frieda M. Kuhlmann, case supervisor, Children's Aid Society, Newark, N. J., showed how case-work techniques, although not specifically gained from experience with blind children, are nevertheless effective because they are based on sound principles of general welfare and child psychology.

Legislative provisions for the blind preschool child were discussed by Dr. Robert B. Irwin, executive director of the American Foundation for the Blind.

Anna W. M. Wolf, senior staff member, Child Study Association of America, described the social and emotional development of the young child in relation to his need for his mother and his later separation from her.

From 20 years of experience in visiting the homes of preschool blind children, Harriet E. Totman, visiting teacher in charge of Braille classes and preschool children with visual defects, Cleveland Public Schools, said that through concern for the blind baby's safety his parents may keep him in his crib months longer than they would keep a seeing child. When he is at last placed on the floor he is seldom permitted more territory than a play pen. After he creeps and even after he walks the cautious mother may keep him long hours in his chair or stroller. This overprotection often makes the child fearful. Miss Totman mentioned also that some parents do not give the little child the opportunity to do things for himself at the time his physical development permits it.

A discussion of tests for blind preschool children, by Samuel P. Hayes, M. D., Perkins Institution and Massachusetts School for the Blind, and Anna S. Elonen, assistant professor of psychology, division of psychiatry, University of Chicago Clinics, brought out that there are as yet no definite and reliable scales, although beginnings have been made. It was agreed that tests must be considered only in relation to the child's behavior as a whole.

Miss Elonen urged that in attacking this problem not only should ophthalmologists, social workers, and psychologists be consulted, but also neurologists, psychiatrists, pediatricians, and obstetricians.

A panel on facilities for the education of blind preschool children presented various provisions for these children, such as the residential nursery and the day nursery especially for the blind; placement in a regular nursery, kindergarten, or foster home; and training courses to help the mother teach the child in the home. It was pointed out that each of these facilities is useful for some children, but that none of them can solve the problem for all.

The guidance and education of the child must be based on his inborn growth potentialities, said Arnold Gesell, M. D., director of the Clinic of Child Development, School of Medicine, Yale University. Dr. Gesell made it clear that the fundamental factor in the child's mental growth is his maturation. Conditioning and learning play a secondary role, he added.

If the blind child is given ample opportunity to assert his natural capacities, said Dr. Gesell, he will tend to traverse stages of maturity that are not unlike those of the seeing child. Dr. Gesell urged that the blind child be encouraged to grope, to reach, to grasp, to manipulate, to stand, to walk, to run, and to play games insofar as his development permits.

Merrill J. King, M. D., Massachusetts Eye and Ear Infirmary and Harvard University School of Medicine, described the status of research on retrolental fibroplasia, a fibrous growth of tissue behind the crystalline lens, occurring most frequently in prematurely born babies. Cases of blindness from this cause have increased, and accord-

ing to Dr. King this can be explained in part by the increased survival rate of premature babies. It is hoped, said Dr. King, that research being conducted at various universities and hospitals will be successful in combating this disease, for which no treatment has yet been found.

A summary of the conference was given by Dr. Berthold Lowenfeld, director of educational research, American Foundation for the Blind. In connection with provision for teaching the blind preschool child, Dr. Lowenfeld said that the accent should be on leaving the child in his home, rather than placing him in a residential school, and providing the family, particularly the mother, with guidance and if necessary with case-work help. Dr. Lowenfeld spoke of the inadequate stalling of State services for parents and blind children in their homes. To meet such a situation he suggested mobilizing community resources, but expressed the hope that State staffs would be provided in increasing numbers.

Helen Keller, the famous blind author, was a guest at the conference. She said:

"It is encouraging to see how parents everywhere are waking up to the importance of preparing their blind children for school as soon as possible after the loss of sight. Truly a child's first years of learning the way he should go are decisive, and anyone who fights the numbing effects of early blindness that arrests the stricken child's naturalness is his guardian angel.

"Let there be light" remains an inviolable decree, and unless the blind child has inward eyes planted in his mind, he is denied that very beauty of childhood. As we all know, left to himself, he is apt to become abnormal and have little or no experience."

Miss Keller said that if when a blind child enters school he is unhampered by the feeling of being different from others, he will not suffer from the obstacles he encounters. After all, she added, it is not a specialty of blindness to conquer obstacles.

"The united influences of parents, teachers, doctors, and the community are necessary," said Miss Keller, "to protect the young blind child against the mildew of broken sense."

CHILD-WELFARE SERVICES

(Continued from page 181)

The State also must keep up with the growing content of social services to children and help practitioners achieve and maintain competence. All staff members, and especially isolated rural workers, need professional stimulation and the opportunity to refresh themselves if they are to grow and give their best service. Professional development does not come by chance, but from a planned, continuous program. This must apply to all staff members, and for professional staff it must include the full sequence of on-the-job training, graduate training, and continued training within the agency upon return from school.

The State has a role in recruitment of staff. We need to dip deep into colleges and high schools to tell about careers in child welfare. Young child-welfare workers with some glamour are probably the best recruiters, just as foster parents are the best finders of new foster homes.

Adequate salaries are needed, but money is not enough. Professional persons want to work in agencies that offer adequate supervision, reasonably secure tenure, and a chance to make a contribution. Many agencies don't pass the test. The candidates for positions select the ones that do.

The State must also lead in making effective use of available personnel. We cannot afford to let talents lie idle. But we are doing just that, even as we cry for personnel. What about the well-trained and experienced social workers of minority groups? With courage, imagination, and conviction, we must employ them and prove our concern for children. Areas cannot be left uncovered or workers stranded without supervision or consultant services. All the genius of administration must be directed to preventing that collapse.

The State welfare department has responsibility for promoting appropriate legislation and defining basic requirements for the care and protection of children. The State department must speak out for laws related to licensing, adoptions, guardianship, interstate placements, juvenile courts, and all areas of child life. This responsi-

bility extends to securing adequate financial support and clarifying administrative difficulties that require legislative action.

Interpretation of the place of social services and of children's needs is a perpetual responsibility of the State, as it is of each local agency. We cannot tell the story too often.

Research and reporting are also basic to the State's function of planning and interpreting its program.

The State department must promote effective relationships within the total public-welfare program. Integration of related programs within one agency can be achieved without loss to any program if the differentiating elements of each are clearly defined and protected. However, we cannot give good service to children unless the special functions, knowledge, understanding, and skills of the child-welfare field are sustained in practice. Nor can we separate child welfare from the total welfare program of which it is a part.

Setting standards and developing comprehensive social services for children also require close cooperation with related organizations. Education, health, recreation, and mental health have expanding programs with which child welfare must be closely and continuously related.

What does it take to get social services to children?

This fifth and last point reminds me of the grasshopper, who, come winter, turned to his friend the ant for a loan of food. The ant suggested he turn himself into a cockroach and live in a rich man's kitchen for the winter. The grasshopper started off with delight, then paused, and called back to the ant, "That's a good idea, but how do I do it?" The ant replied, "I've given you the broad outline. It's up to you to fill in the details."

How do we fill in the details? As case workers, supervisors, consultants, directors, board members, we must reach out to children. Often when a child needs help, the first reaction is to doubt whether the service comes within our responsibility or function. Let us stop holding back and reach out to serve.

What does it take to serve children in this way? We know it takes special skill and understanding. There are different ways of communicating with children and of understanding their feelings, which they rarely express verbally. There are special skills in helping without being asked to do so and in carrying the responsibility for what happens to children. The complications of the three-way relationship of child, parents, and foster parents cannot be directed without skill; and also the ramifications of supporting resources and community experiences.

To understand the child who has a problem the worker must know what is normal development for children of different ages and experiences. Why do adolescents run away to seek recreation in another town or neighborhood when they have a teen-age center close at hand? Why does an infant suddenly seem afraid of the same persons to whom he responded happily a short time ago? Why does Jack know everyone at school and his brother practically no one?

Then there is that scientific body of knowledge about children who have special problems. What are the pressures of group living for the child in an institution? Can Alfred take on a new mother? Why does Mary dislike the foster home that has all the things she wanted? The child-welfare worker must know about communities, which are as individual and complicated as children; about government with its realities; about all kinds of agencies and their programs. What can an advisory committee do that is genuine and sound? How can latent community interest be made to work for children? We know about the knowledge and skill this job takes, and the urgency of getting trained staff. And we know the need for appropriate legislation, adequate financing, and sound administrative practices and relationships. Those are the things it takes to raise services for all children to the standard that has been achieved for some.

What are we waiting for? We know what should be done. We know who must do it! We have the know-how. Let us move forward until social services for all our children become a reality.

UNMARRIED PARENTHOOD; a study of 1,839 unmarried parenthood cases, prepared by Helen C. Dean, Welfare Council of Metropolitan Los Angeles, 1946. 133 pp. \$2.50.

Twenty-six agencies, public and private, participated in this study of unmarried parents, which focuses attention on the nature and extent of services in Los Angeles for unmarried mothers and fathers.

The agencies included 10 family-welfare agencies; 4 child-welfare agencies; 6 health agencies; 3 maternity homes; 2 authoritarian agencies, which offer protective services in addition to their basic purpose of juvenile-delinquency prevention and control; and the State department of welfare.

The report presents statistics on the age, race, religion, residence, occupation, and marital status of the mothers; the occupation and marital status of the fathers; the sources of referral; and the nature of the requests for help. These figures are given for all the agencies combined and for the agencies grouped according to function.

A copy of the schedule used and a selected, comprehensive bibliography are given.

Although the findings of the study apply specifically to Los Angeles, the report is a good example of how research and statistics can be used effectively in evaluating the strengths and weaknesses of a community social-welfare program so as to assist in planning to extend and improve needed services.

I. Richard Perlman

THE CHILD FROM FIVE TO TEN by Arnold Gesell, M.D., and Frances Ilig, M.D. Harper & Bros., New York, 1946. 475 pp.

There is a verisimilitude about many of the descriptive sketches in this book of the behavior, interests, and outlook of children 6 to 10 years old that gives reason enough for the delight with which many parents will hail its appearance. They will recognize the 6-year-old who grabs for food, knocks things over, wriggles in his chair, teeters back, and kicks the table legs. And the 8-year-old who scorns some of the simple earlier games and may make up his own games, with rules. Recognition by fathers and mothers of some or their own child's characteristic behavior is lots of fun and it has reassurance value, too.

But in such an attempt as this to show in great detail what may be looked for at various ages there are bound to be snares to catch the unwary. What por-

tion of parents using the books will note in the introduction that the findings were based on the study of less than 70 children, all told, and that these children were "representative of a prosperous American community?"

Among these selected children the 9-year-old girls "have usually been told about menstruation." But will some readers get the impression, therefore, that this applies to 9-year-old girls in general?

Will some be puzzled by the idea that a child 5½ years old "holds his pencil more awkwardly" than he did earlier?

And where does environment come in? No mention is made of the kind of home and family setting that has influenced the behavior. When we are told that the 8-year-old "does fairly well with younger siblings" and that the 9-year-old "frequently gets on well with his siblings" are we to assume that this is true regardless of the number of brothers and sisters, their ages, and the way their parents manage them?

Although the authors emphasize over and over again that "the maturity traits are *not* [authors' italics] to be regarded as rigid norms, nor as models," the reader has an almost irresistible tendency, in referring to such an outline of development, to measure the child he has in mind.

The chief aim of the book, says the introduction, is "to impart a sense of growth trends." Perhaps it is not possible, using chronological ages as the frame into which the behavior sequences are fitted, to avoid the illusion of steps in behavior and attitudes, rather than flowing, meandering trends.

The book reflects unmistakably the immense amount of loving, painstaking work that has gone into assembling the observations. The humorous, casual way in which many of the behavior items are phrased gives a much-to-be-desired impression that parents may as well accept a lot of these items lightly, exclaiming "O tempora! O mores!" instead of glooming over them as "problems." And there are innumerable suggestions that will cause parents to think twice about whether they are fair in what they expect of their children—in itself a decidedly worthwhile outcome of any parental attempt at self-education.

Marion L. Faegre.

SOME DYNAMICS OF SOCIAL AGENCY ADMINISTRATION. Family Service Association of America, 122 East Twenty-second Street, New York 10, 1946. 76 pp. 75 cents.

A series of papers, by different authors, focused on the role of the executive, but emphasizing also the interrelation of membership, board, executive, and staff in agency planning.

STOP SNIPING AT PARENTS

(Continued from page 185)

trists that they will have the confidence of all the families in the community. Some people believe that only the children of lower-income families need the services of such workers. But a brief chat with the local chief of police should convince us all that the children of families in higher-income groups *do* break the law, and there is no reason why these families should not have the same privilege as others in seeking advice and guidance from a reputable family-service agency or child-guidance clinic.

There are people who argue that it is a waste of time and money to support such corrective agencies. They say it is wiser and less expensive to concentrate on preventive measures, such as well-supervised recreation and improved education. The reasoning is that delinquency can be prevented by providing the type of education which is suited to the capacities of each child and also by after-school recreational programs which would meet the child's need for adventure and constructive social experiences under skillful and trained leadership. We agree that such measures are necessary to a sound community program, but we disagree that education and recreation can take the place of treatment. Both are essential. In dealing with typhoid, it is indeed wise to think of purifying the source of the city water supply, but who is so rash as to minimize the typhoid victim's need for treatment?

The job ahead is not easy. The solution is not simple. Blaming the parents solves nothing; it merely pours salt on open wounds. In the future, when we see a child with a misguided or warped personality, let us not fall in with the temptation of blaming the parents. Let us, rather, help the parents to understand and make use of the services of the family agency or the guidance clinic. Let us help them to seek out the appropriate recreational agency where a child may find not only satisfying activities but, even more important, human contact with adult leaders. Let us stop criticizing the parent. Let us begin to practice the good-neighbor policy in our own neighborhood!

Reprints available in about 5 weeks

Civic Council Acts as Information Clearinghouse on Children and Youth

In Oshkosh, Wis., the Civic Coordinating Council conducts a continuous program of giving information to the public about the needs and opportunities for children and youth in the city and of receiving information and recommendations from the public.

The council is a planning body, founded on the conviction that "in every community there should be a group of citizens reviewing what children and youth need, exploring the extent to which such needs are met, and stimulating community agencies and planning groups to develop services or policies found to be necessary."

The members are representatives of citizens' organizations serving children and youth; of public health, social-service, and family-welfare agencies; of public and private child-caring and protective agencies; of the juvenile court; of departments of the city government; of educational, church, labor, employer, and farm groups; and of youth organizations. It draws its information from this broad membership, from agency studies and reports, from special research, and from the reports and complaints that come to it because of its announced function as a clearinghouse.

The broad objectives of the council are:

1. To strengthen the resources for fulfilling the needs of all children.
2. To protect groups of children especially vulnerable to delinquency.
3. To control harmful influences in the community.
4. To provide services for the delinquent child and the child with behavior problems.

In the furtherance of these objectives the council is emphasizing this year an eight-point plan: A parent-teacher association in every school, with a central executive council to coordinate the efforts of these groups; a program of family-life education; a laymen's interdenominational group for better understanding of youth groups and their common problems; suitable detention facilities for children and youth needing such protection; a full-time psychologist to assist in treatment of youthful offenders; an increase in taxes to provide recreational facilities; day care for children of employed mothers; counsel-

ing and placement services for youth wanting to enter industry; and finally, advisory service for parents and youth.

The president of the Civic Coordinating Council is Mr. F. Orville Weber, 224 Grove St., Oshkosh, Wis.

Stella Seurlock

Three States Report Advances in Work for Children and Youth

Louisiana Juvenile Court Commission gets under way

Louisiana's Juvenile Court Commission, authorized by a former legislature, was activated in November 1946 when the Governor appointed its five members, including the commissioner of public welfare, the dean of Tulane University School of Social Work, two judges, and the president of the State parent-teacher association. The commission is now getting under way, with Ethel K. Muse of the State public welfare department as executive secretary. Miss Muse has previously served this department as child-welfare consultant and as appeals referee.

The commission is authorized to study juvenile-court standards in the various States and to make a survey of juvenile delinquency, neglect, and dependency throughout the State of Louisiana, with a view to proposing measures to protect children and to modernize the juvenile courts.

New Jersey Governor's conference on youth

The Governor of New Jersey is calling a conference on youth in May "to implement the conclusions and recommendations of the National Conference on Prevention and Control of Juvenile Delinquency," held in Washington in November 1946. A "core committee" of about 40 members, appointed by the Governor, decided at its first meeting in February that the program of the conference will be patterned after that of the national conference, with emphasis on the general promotion of the welfare of youth. Panels on community organization, home, housing, school, church, recreation, police, juvenile court, detention, treatment facilities, health, and public opinion will meet in advance to prepare reports.

The conference will be organized in subject-matter divisions, and each panel will present its reports to one of the divisions for discussion and implemen-

tation. The division meetings will consider, also, eradication of harmful influences, services for delinquent youth, and general youth services.

High-school and out-of-school youth will be included in the membership of these panels, along with representatives of citizens' organizations, public and private agencies, and experts in the designated fields.

A general program committee of about 25 persons "broadly representative of youth-welfare interests" will receive and study the panel reports and route them to the conference divisions. Judge Richard Hartshorne is chairman of this committee, and Douglas H. MacNeill, director of the division of community services for delinquency prevention, is secretary.

Arkansas Council on Children and Youth

On March 28, 1947, the Arkansas Council on Children and Youth came into being, when the Governor signed a bill creating it.

Its duties will include:

1. Making a continuous study of the educational, health, recreational, welfare, moral, and spiritual environment of children and youth in Arkansas and of their economic and working conditions, with the object of improving these conditions.

2. Reviewing legislation and appropriations pertaining to services for children and youth, and suggesting revisions.

3. Appraising the adequacy and accessibility of existing services for children and youth.

4. Formulating programs for improving existing conditions, after consultation with individuals and agencies concerned with the welfare of children and youth.

The Governor will be the honorary chairman, and the State commissioner of education, the State health officer, the State commissioner of welfare, and the State commissioner of labor will be the permanent members. These permanent members will appoint not more than 21 rotating members from organizations, agencies, and institutions interested in the welfare of children and youth.

The four State departments represented by permanent members will present to the council from time to time the results of studies in the areas of child and youth welfare, and will also investigate problems referred to them by the council.

The new law is the result of the work of the Governor's Committee on Arkansas Children, under the chairmanship of Mrs. Scott Wood, which has been

carrying on a program of study regarding the welfare of Arkansas children and youth for several years.

Stella Scurlock

They Need You

THEY NEED YOU is a project to bring about better understanding between American and European youth. As a step in carrying out this project several articles have been prepared, addressed to the young people of the United States, describing the plight of the children in Europe and suggesting ways to help. These articles are published in pamphlets that are sold at a nominal price, which only partly meets the cost of printing, mailing and handling. The titles are: "What One Friendly Gift Can Do," "Misery of Children in War-Torn Countries of Europe," and "How It Feels To Be Hungry." Single copies are 5 cents; 100 copies or more 4 cents each. Write to **THEY NEED YOU**, 21 South Twelfth Street, Room 226, Philadelphia 7.

The pamphlet entitled "What One Friendly Gift Can Do," says: "You as an American have plenty of food, clothes, good schools, loving care, and medicine when you are ill; therefore you surely would like to share with those European children who have so few of these things."

Summer Courses

Louisiana State University School of Social Welfare, Baton Rouge 3, will offer a 3-week, a 9-week, and a 12-week summer term beginning June 9; also two 3-week courses, beginning June 30 and July 21. The subjects include juvenile delinquency, a workshop in services to children, child-welfare problems, and trends in child welfare.

Mills College, Oakland, Calif., is offering its Summer Session in Child Development. For further information write to Mills College, Oakland 13.

University of Southern California, Los Angeles, will conduct its second workshop in intercultural education, carrying six units of graduate credit. It includes a lecture series, entitled "Racial and Cultural Tensions in America." Further information from the School of Education, University of Southern California, Los Angeles 7.

University of California, Berkeley 4, announces a 6-week training center in

family life, health, and social relations for high-school and college teachers, counselors, nurses, parent educators, supervisors, and community health workers (June 23 to August 2).

New York School of Social Work, Columbia University, New York 10, will hold three series of summer institutes for experienced social workers at the school, and additional ones at Camp Edith Macy, Pleasantville, N. Y. Series I, July 14-25; Series II, July 28-August 8; Series III, August 11-22; and Camp Edith Macy, September 3-16.

Dr. Eliot, Chief Medical Consultant to International Childrens' Emergency Fund

Dr. Martha M. Eliot, Associate Chief of the U. S. Children's Bureau, has been lent to the International Children's Emergency Fund for 4 months to serve as its chief medical consultant.

She left April 25 for Paris to join the chairman of the executive board of the ICEF, Dr. Ludwik Rajchman, for visits to several European countries to develop plans for the operation of the Fund. She will visit France, Czechoslovakia, Poland, Austria, Yugoslavia, Greece, Italy, and Switzerland.

She will return to the United States the first week in June and her headquarters for the remainder of her time with the ICEF will be her office at the Children's Bureau.

Conference Report Postponed

We are postponing till a later issue the report of the recent conference at the Children's Bureau on the child with cerebral palsy.

Children's Bureau Has Thirty-fifth Anniversary

April 9, 1947, marked the beginning of the thirty-fifth year of the Children's Bureau. On that day in 1912 an act of Congress establishing the Children's Bureau received Presidential approval. This act requires that the

Bureau "shall investigate and report * * * upon all matters pertaining to the welfare of children and child life among all classes of our people, and shall especially investigate the questions of infant mortality, the birth rate, orphanage, juvenile courts, desertion, dangerous occupations, accidents and diseases of children, employment, legislation affecting children in the several States and Territories."

CONFERENCE CALENDAR

June 2-4, 1947—National Congress of Parents and Teachers. Chicago.

June 9-13—American Medical Association. Ninety-sixth annual session. Atlantic City.

June 17-20—National Tuberculosis Association. Forty-third annual meeting. San Francisco.

June 23-26—American Home Economics Association. Thirty-eighth annual meeting. St. Louis.

June 23-28—General Federation of Women's Clubs. Annual convention. New York.

July 6-12—American Physiotherapy Association. Twenty-fourth annual meeting. Asilomar, Calif.

July 9-13—First Pan American Congress of Pediatrics. Washington.

July 14-17—Fifth International Congress of Pediatrics. New York. This international congress was to have been held in Boston in 1940, but had to be postponed because of the war. Further information from the secretary, Dr. L. Emmett Holt, Jr., Bellevue Hospital, New York 16.

We wish that every baby could have the good health that the cover girl on our May issue shows. The photograph is by Philip Bohn for the Children's Bureau.

Other credits:

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CHILD HEALTH DAY, 1947
BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A Proclamation

Whereas the Congress, by a joint resolution of May 18, 1928 (45 Stat. 617), authorized and requested the President "to issue annually a proclamation setting apart May 1 of each year as Child Health Day and inviting all agencies and organizations interested in child welfare to unite upon that day in the observance of such exercises as will awaken the people of the Nation to the fundamental necessity of a year-round program for the protection and development of the health of the Nation's children"; and

Whereas every citizen of our country has an inescapable obligation to aid in insuring the American child's birthright of health and of freedom from handicaps; and

Whereas accidents are the leading cause of death and an important cause of crippling among children:

Now, therefore, I, HARRY S. TRUMAN, President of the United States of America, do hereby designate May 1, 1947, as Child Health Day; and I invite interested individuals and agencies to observe the day with appropriate ceremonies designed to stimulate interest in and devotion to the cause of child welfare in the coming year.

I call upon parents to dedicate themselves on that day to the exercise of unusual diligence throughout the year

toward the prevention of accidents in the home, so that the children may be protected from needless injury and suffering and may receive and enjoy the blessings of health and happiness.

In witness whereof, I have hereunto set my hand and caused the seal of the United States of America to be affixed.

Done at the City of Washington this eighth day of April, in the year of our Lord nineteen hundred and forty-seven, and of the Independence of the United States of America the one hundred and seventy-first.



Harry S. Truman

By the President:

Dean Acheson

Acting Secretary of State.

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FEDERAL SECURITY AGENCY
SOCIAL SECURITY ADMINISTRATION

CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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THE

JUNE 1947

CHILD

Over



WHEN A CHILD HAS CEREBRAL PALSY

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CEREBRAL PALSY, or "cerebral spastic paralysis," is becoming one of the greatest causes of crippling among children. The number of children crippled by some diseases, such as rickets and tuberculosis, is decreasing, but there is no likelihood that cerebral palsy will be conquered soon. Surveys in several States indicate that each year seven infants with cerebral palsy are born per hundred thousand of the population.

Practically all these children are greatly handicapped in body, but only 25 to 30 percent are feeble-minded. The remaining large number should be trained and educated in such a way that they can develop into happy and capable members of society.

This is no easy task, but it can be approached with more chance of success if the child's parents, his teachers, and all workers concerned with him understand the conditions that bring about the problems in caring for these children. Let us ask, then, what is cerebral palsy?

Cerebral palsy is not a single entity; it represents several conditions, which are grouped together because they all are caused by injury or disease of some part of the brain.

Different functions of brain affected

The brain is such a complex organ, and it has so many functions, that a body condition resulting from injury or disease in one part of the brain is likely to bear little or no resemblance to one resulting from injury or disease in another part.

The chief functions of the brain are: First, reception of incoming stimuli, as in seeing, hearing, touching, smelling, and tasting; second, the work of the actual thinking part of the brain, in which the stimuli that come in are organized and reviewed; and third, the motor or activity work—the sending of outgoing stimuli from the brain to move the various parts of the body such as the

arms, the legs, and the speech mechanism.

In cerebral palsy, any or all of the three functions of the brain may be affected, according to where the injury is. Thus not only are the child's motor powers affected, but the sensory, and sometimes the mental powers as well. Many attempts to teach children with cerebral palsy have failed because only the motor disturbance has been given attention, and the child has been treated in the same way as if he had the motor disturbance that results from infantile paralysis, which is an entirely different condition.

It is not possible to consider as a whole the group of conditions known as cerebral palsy. It must be broken into its various types and these types must be recognized by anyone who is planning to teach these children. This does not mean that in order to teach such a child one must be medically trained, or must know the medical details of cerebral palsy. Rather, one must be familiar with the various types and be able to recognize them with a reasonable degree of accuracy in order to understand the difficulties in learning that these children have.

If a child has only one handicap, such as blindness, paralysis, deafness, or lack of speech, it is easier to plan ways of teaching him than if he is a child with cerebral palsy, who practically always has combinations of handicaps. Any one of the handicaps may be minor when considered alone, but when two or more are joined they may make the problem of teaching him very difficult.

In training a child with cerebral palsy we must remember that he has had his handicaps ever since he was born; and we must realize that many fundamentals such as alternating the legs, reaching, and grasping, which a normal child learns of himself early in life, must be taught to the child with cerebral palsy.

Muscles can act wrongly in various



Apparatus that guides him and aids him in maintaining his balance is helping this cerebral-palsied boy to learn to walk.

ways. For example, in infantile paralysis, it is simply impossible for the child to move his muscles when he wishes. In cerebral palsy this type of paralysis is seen only occasionally. The opposite condition, however, in which the child's muscles move whether he wishes them to or not is frequent in cerebral palsy. The child's arms or legs or face move without his making any voluntary efforts. This condition is called *athetosis*; it occurs in 30 to 45 percent of the children with cerebral palsy.

When muscles move involuntarily

In athetosis, when the child's muscles move of themselves, the involuntary motions will upset his attempts to make normal motions. The trouble that this causes to the child depends on what part of the body is involved.

For example, it may be the face, and many children have been wrongly clas-

Excerpted from a more comprehensive paper by Dr. Phelps.

fied as mentally defective because of grimaces, other facial contortions, drooling, and disturbances in speech, brought on by involuntary motions. Incidentally, such difficulties should be entirely disregarded when we are attempting to determine a child's true

cases are of this type. The fact that the proportion is so small makes it unwise to speak of all children with cerebral palsy as spastics, as so many persons do.

The true spastic has extreme stiffness in the muscles whenever he tries to move them. This slows up his motions and

one can see a definite difference between them.

Balance disturbed

The third type of cerebral palsy is *ataxia*, which represents about 10 to 20 percent of cerebral-palsy cases. Children with ataxia do not make involuntary motions, nor are their muscles stiff, but they do have severe disturbance of balance. Often they cannot control the motions of their eyes, and this tends to make them dizzy or otherwise uncomfortable when they try for long to fix their gaze on anything, such as a printed page. It is obvious that these children would have difficulty in sitting erect, in using the legs accurately in walking, and in using the eyes in reading and writing.

Intelligence may be damaged

About 10 to 20 percent of cerebral-palsy cases are represented by the fourth condition, which is called *rigidity*. This is characterized by a resistance in the muscles like the resistance felt in bending a lead pipe. It is usually intermittent, but generally takes place whenever the child attempts voluntary motion. It is associated with perhaps more damage to the intelligence than any of the other types of cerebral palsy. Rigidity is more closely related to spasticity than to any of the other types in its effect on muscular control and in its treatment.

The fifth type of cerebral palsy is known as *tremor*. About 5 to 10 percent of all the children with cerebral palsy have this type. It is characterized by rhythmical involuntary motions of the muscles. The child's mentality is usually good. Tremors are something like athetosis in their effect on the child's muscular control and in the treatment needed.

In all five of the types of cerebral palsy there are three fields of motor difficulty. These represent the legs with regard to locomotion, the arms with regard to self-help, and the speech and face mechanism. We are combining the speech and the face, since children with speech defects usually, although not always, have an accompanying lack of control of the facial muscles.

On the sensory side, the child with cerebral palsy may have difficulty with vision, owing to abnormal or involun-



Playing "telephone" is fun for Ina and Jo, who have speech difficulties that are due to cerebral palsy. This kind of play is helping them to relax while trying to walk, and they are learning to express themselves without tension.

mentality, which exists behind the mask of involuntary motion.

When the involuntary motion occurs in the legs, the child of course has difficulty in walking, and usually some difficulty in balancing.

If it is the arms that are affected, the result is like trying to write in a moving train or automobile.

The child may try to control the involuntary motion by holding himself very tense. But this does not help; in fact, it often makes the involuntary motion worse. The tension often becomes habitual, and so strong that the child finds that he can hardly let go. This attempt to hold still is not universal among athetoid children; it occurs in about half of them.

Two types easily confused

Spasticity is the second type of motor difficulty that occurs in cerebral palsy; about 30 to 45 percent of cerebral-palsy

makes them very laborious. But he is able eventually to accomplish the motion, and with a considerable degree of accuracy. The stiffness may disappear almost completely when the child is sitting still.

The spastic child, especially if only one part of the body is involved, often has decreased sensation. Such a child may make little use of an arm that fundamentally has fairly good function, because he is unable to feel clearly any object that he grasps or holds. He feels as though he were trying to use the hand covered with a heavy woolen glove. This would of course deter the child from using the arm in all sorts of activities. It would not hinder him so much in using his legs, since finer degrees of sensation are not so necessary for walking.

The athetoid and the spastic child can easily be confused, but by observing each type closely over a period of time

tary motions of his eyes, which would greatly affect reading and writing.

The athetoid child especially may have limited hearing. In some of the athetoid group there is a rather characteristic type of hearing defect, which is frequently overlooked. This defect is on a pitch basis entirely and is not related to the loudness of the sound. This hearing defect has been discovered in children even as old as 8 or 9 years, whose parents have never been aware of it.

Whether the child has this type of hearing defect can best be determined by studying the type of speech defect he has and the pitch at which his hearing is cut off. This can be done by noticing which sounds are lacking in his speech, since no child will use sounds that he does not hear some other person use.

When the point of cut-off is low, many words sound alike to the child, and he can hardly make out what people say to him. We can easily see this makes the child answer in a way that leads many grown people to consider him a behavior problem.

Some of these children are even considered mentally defective because they do not respond normally when spoken to.

Still others have had their speech defect wrongly attributed to athetosis in the tongue, with inability to form the words. Of course, athetosis does occur in the tongue, and there are athetoid speech defects that are definitely associated with limitation in proper use of the tongue, but we must not confuse these speech defects with those due to an unrecognized hearing defect.

It is not always possible to carry out careful audiometric tests on these children, and so we must place a great deal of dependence upon the type of speech defect and the determination of its cause.

If the child is consistent in certain omissions and mispronunciations, we can assume that the speech defect is due to a hearing defect.

The true athetoid speech defect, due to involuntary motion in the tongue, is entirely different in that the child may not pronounce a word the same way twice, since the involuntary motion in

his tongue can never be synchronized with the voluntary motion.

In the spastic child, on the other hand, there is little probability of an associated hearing defect, and the speech in the spastic is very characteristic. The tongue shows spasticity, and although the child has a definite speech defect the "language" can be learned by those associated with spastics.

The speech of the ataxic child is different from that of the other types because the position of his tongue is indefinite; he is not able to place it accurately.

It is obvious, therefore, that the treatment of these various types of speech defects will only be accomplished after very careful distinction is made between them.

Obviously a child with such motor and sensory difficulties as have been described, who must grow up in our complex environment, will have psychological difficulties that workers with these children should understand.

Types differ in psychology

The psychological limitations imposed on the child that does not walk are difficult to measure. A child's self-teaching is to a great extent dependent upon the fact that he is able to crawl around at first and later to walk around, touching all sorts of objects and coming in contact with a variety of materials. How much this environmental learning is limited by the child's inability to walk or crawl at the proper time is, of course, extremely difficult to determine.

It is equally difficult to measure the psychological limitations caused by the child's inability to use his arms in coming in contact with various materials and objects.

And when the limitation in the proper use of the arms and legs is combined with an eye defect, a hearing defect, or a lack of sensation, such as is found in the spastic, it is practically impossible to evaluate the child's potentialities for learning.

If a child cannot speak but has good control of the arms, and has no mental defect, he always develops a speech substitute or sign language of some sort.

However, if his limbs are affected so that he cannot develop a real sign language, then his way of communicating with others is definitely limited, and it is again impossible to measure the effect of this on his fundamental abilities. Such a child will develop a psychological set-up entirely different from the normal one.

Although the distinction between the types is much less in the psychological field than in the motor, there are a few fundamental psychological attributes



Weaving helps a cerebral-palsied child to learn muscle control of arms and hands. Bill can run a loom from a wheel chair.

which are observable in these children in their respective groups.

Thus, for example, the athetoid child as a rule is not fearful, whereas the spastic child is likely to be filled with fears of many kinds, and this considerably limits his activities. The ataxic child is about like a normal child with regard to fear.

Affection is highly developed in most athetoid children, whereas the spastic is likely to show affection only when seeking protection. The athetoid, typically, is extraverted and makes friends easily and is not particularly concerned about his handicap. The spastic, on the other hand, usually is introverted and is fearful of strangers, and as a rule

takes considerable time to make friends.

The athetoid child tends to show a great deal of rage or anger and is likely to have strong dislikes; the spastic, usually, is much slower to anger and does not stay angry long.

The child with rigidity and the one with tremor resemble the spastic and the athetoid respectively in these two respects.

It is very difficult when working with cerebral-palsied children to distinguish the psychological emotional set-up of

is combinations of difficulties that bring about the hardest problems; and that practically every one of these children has more than one handicap, caused by the disease.

When handicaps are combined

Which parts of the child's body are affected by his brain injury will have varying effects on his needs and on his learning.

If, for example, his legs are affected, he will need transportation, especially

to many cerebral-palsied children; and a hearing aid is often a step toward a child's learning to talk.

A case which may be cited at this point is that of a boy of 10, whose legs, arms, and speech were involved.

Much medical and surgical work had been done on his legs, to no avail, but little or no training had been given him in using his arms or in speech. He had had no schooling whatsoever because of his difficulty in speaking and in using his arms.

Training in use of his arms and in speech was begun, and after 3 years his arms were rehabilitated to the point where he could dress himself, wheel himself in a wheel chair, and take care of himself at the toilet. The speech was improved so much that he could be understood quite well.

It was decided that no further attention should be paid to the legs.

This boy was able to wheel himself in and out of his house, which was built on ground level; down to the corner store; and to a school in the neighborhood; and he was freed from the necessity of being cared for entirely by another person.

This case is given simply to bring out the relative unimportance of actual walking. Use of a wheel chair, with some training of the child to get in and out of it, is relatively satisfactory in most instances, and rehabilitation of speech and arms in cases of this sort is far more important than of the legs.



A speech therapist who understands Bobby's type of cerebral palsy is discussing his toys with him. She spends a short time with him daily, and keeps in touch with his teacher and his parents so that they can all work in the same direction.

a child whose mentality is fundamentally normal from that of a defective child. Of course, there are defective children among those with cerebral palsy, but the percentage of children with true mental defect due to damage to the actual thinking part of the brain—not the motor or the sensory part—represent only about 33 percent of the total number with cerebral palsy. In the presence of great difficulties in testing and evaluating the mental level in these children, it can only be said that all of them should be given every opportunity to learn, after all their various handicaps have been taken into consideration.

In helping the cerebral-palsied child to learn, we must keep in mind that it

when he is ready to go to school.

Involvement of the arms is important with regard to the child's being able to help himself in dressing and undressing, wheeling a wheel chair, and using the toilet; and, later, in turning pages and in writing.

The third involvement—of speech and face—is primarily a handicap in regard to the child's learning to talk. But, of course, involuntary movements of his face will affect his relations with other people, especially at school.

If the child's sight or hearing is affected, the usual methods for helping such children may be used; but the special types of hearing defects mentioned earlier should be kept in mind. Eyeglasses and hearing aids will be of use

If a child with cerebral palsy is to be given the best possible help, any person who is working with him should know enough about the various aspects of the disease to make sure that the efforts to teach the child are not wasted because the methods used are not suited to his needs.

When these various aspects of cerebral palsy are distinguished, and the needs of the child as an individual are recognized, we can help the cerebral-palsied child to lead a life that is as nearly normal as is possible in view of his handicaps.

Reprints available in about 5 weeks

EXPLORING THE PROBLEMS OF THE CEREBRAL-PALSIED CHILD

"Treat the child with cerebral palsy first as a child, then as a handicapped child, and last as a cerebral-palsied child," said Myer Perlstein, M. D., medical director of the Mandel Clinic, Michael Reese Hospital, Chicago, speaking at a conference on children with cerebral palsy that was held by the Children's Bureau March 26-28 at Washington.

The conference was the first one of its kind in that it consisted of a small group of experts in various fields, each of which is important in the care and training of the cerebral-palsied child. The fields represented included pediatrics; neurology; orthopedic surgery; nursing; physical therapy, occupational therapy, and speech therapy; medical-social work; psychiatry; psychology; and special education. These professional workers met to pool their experience in preparation for a major effort by the Children's Bureau and the State crippled children's agencies to help cerebral-palsied children, of whom it is estimated that there are 175,000 under 21 years of age in the United States.

It was pointed out at the conference that up to now little help has been available to any considerable number of these children, many of whom though normal in mentality cannot walk or talk, cannot dress and undress themselves, and of course cannot learn to support themselves in adulthood after they are grown up.

Many wrongly thought deficient

Many of these children are entirely neglected. Many whose handicaps are entirely physical are wrongly considered mentally deficient and are in institutions for the feeble-minded. Some are kept at home, but are hidden from neighbors and other persons. Many of these children, it was agreed, could lead happy and useful lives if only the services they need could be provided for them.

The special purpose of the conference was to review the needs of these children; to explore methods for providing special services to them; and to

formulate principles, policies, and standards that may serve as a guide to State agencies in the development of these services.

Several aspects of the special problems of the cerebral-palsied child were discussed, the medical, the psychological, the social, and the educational; and it was stressed throughout the conference that these problems can be met only through teamwork by representatives of several professions.

Individual plans needed

The conference agreed that a thorough appraisal of each child's condition is a necessity, and so is a plan of care developed individually for the child.

After the members had discussed, in several sessions, methods of meeting the needs of these children, and principles and standards of service in meeting their needs, the conference was formed into four committees: (1) On administration of services for cerebral-palsied children; (2) on the services themselves; (3) on facilities for providing these services, and (4) on personnel and training. Each of these committees included a member of the Children's Bureau staff.

The committee on administration, reporting to the conference on development of a satisfactory program for cerebral-palsied children, called for special emphasis on locating infants and young children with cerebral palsy in order that they may be helped in getting a better start in life.

In addition, the committee suggested that preliminary diagnosis or screening be done through field clinics in local communities; that each child's case be reviewed in a central diagnostic center for a thorough appraisal by a team of persons in the medical, psychological, educational, social, and special therapeutic fields concerned with cerebral palsy.

The committee on administration further suggested that State programs should provide all the necessary services. These were listed as medical, physical, occupational, and speech therapy;

special education and training; and vocational education and training; also education of the parents to help them in understanding the needs of their child and in trying to fulfill these needs.

The need for a special advisory committee, including representatives of voluntary agencies and parent groups as well as the various professions, to advise the State agency operating the program for children with cerebral palsy was pointed out by the committee on administration.

Consideration was given to the need for over-all medical direction and for coordination of the proposed services. It was agreed that a pediatrician with wide knowledge of growth and development and with neurological orientation would be well prepared to undertake such a position, but that a physician with some other background in the children's field, such as an orthopedic surgeon, also could serve effectively as director of these services.

The same committee urged joint planning on services for the cerebral-palsied child on the part of State agencies—not only the official State agency responsible for crippled children's services, but also other State agencies in the fields of health, education, and welfare.

In addition, the committee considered the types of children to be admitted to such a program, and agreed that a State program should accept, at least for diagnostic services, all children with cerebral palsy, irrespective of their mental status.

The types of services considered essential in a program for children with cerebral palsy were listed by the committee on services in its report. These are: Case finding, diagnostic services, treatment, recreation, education, vocational and social rehabilitation, and foster-home services.

The value of home life for the child was stressed, and the committee recommended that services should be provided in the child's own home as well as in treatment centers.

For the child who has a good mentality but whose physical handicap is so severe as to preclude hope for benefit from treatment, custodial home care should be provided, this committee reported. In such custodial homes, said

the committee, there should be opportunity for social companionship, recreation, and music appreciation, as well as for education.

It was agreed that the child with low mentality should, after he is carefully studied, be cared for in an institution for the feeble-minded. But before such a child is referred to the institution he should be taught, insofar as possible, to walk and to feed himself and otherwise to make himself more easily cared for.

Teamwork most important

The committee on facilities worked in close cooperation with the committee on services, as it felt that actual physical facilities were of less consequence than the services that the program could provide. That is to say, the important thing is that centers for children with cerebral palsy be developed in such a setting as will allow for consultation with a variety of medical specialists and allied professional workers as may be needed to give the child his best opportunity to develop. Such centers, it is hoped, will help to give the team of professional workers for the cerebral-palsied child a balanced point of view. Both committees recognized, however, the urgent need for suitable diagnostic clinics and long-term convalescent facilities for services to these children.

Basic training not enough

The committee on personnel and training stressed the fact that each member of the professional team concerned with the cerebral-palsied child needs special training, beyond the basic professional training, but made no recommendations as to how much time should be devoted to this special training, or what it should include. The possibility was considered that a few special units need to be set up, in connection with university clinics, where postgraduate training could be given to all the types of professional workers for the child with cerebral palsy.

The matter of trained professional personnel is urgent and is one of the greatest problems the various State agencies for crippled children's services will have to face in developing their programs for children with cerebral palsy, the committee agreed.

In conclusion, the conference pointed

out the great need for research in a number of fields, as a basis for the development of sound programs for children with cerebral palsy. Dr. Perlstein urged further research on the causes of the disease. Dr. Jessie M. Bierman, chief, Crippled Children's Services, California State Department of Health, urged that studies be made of the distribution of the disease in rural and urban areas, by race, by economic status, and by availability of medical facilities.

Study of the family histories of children with cerebral palsy is needed, according to Dr. Bronson Crothers, Children's Hospital, Boston. Dr. Temple Fay, medical director, Neuro-Physical Rehabilitation Clinic, Philadelphia, suggested the need for research in such matters as the speech mechanism.

The conference was in entire agreement that research was needed in determining the characteristics of the special preparation of each of the professional workers in the programs. Dr. Frank A. Disney, pediatrician, cerebral-palsy unit, Strong Memorial Hospital, Rochester, N. Y., told of research now going on at that hospital with regard to muscle function.

The following attended the conference:

Emily Adams, physical therapist, Oakman School, Detroit.

Dorothy Baethke, physical therapist, Chicago.

Bernadette Banker, superintendent, Sigma Gamma Hospital-School, Mount Clemens, Mich.

Dr. Harry V. Bice, psychologist, New Jersey Crippled Children's Commission, Trenton.

Dr. Jessie Bierman, chief, Crippled Children's Services, California State Department of Public Health, San Francisco.

Dr. R. E. Bruner, assistant medical director, Children's Rehabilitation Institute, Cockeyville, Md. (representing Dr. Winthrop M. Phelps).

Miriam Buncher, medical-social worker, Detroit Orthopedic Clinic, Detroit.

Dr. Earl Carlson, Pompano, Fla.

Dr. Bronson Crothers, Children's Hospital, Boston.

Dr. Frank A. Disney, pediatrician, cerebral-palsy unit, Strong Memorial Hospital, Rochester, N. Y. (representing Dr. Plato Schwartz).

Dr. Lucille Eising, orthopedist, cerebral-palsy unit, University of California Hospital, San Francisco.

Dr. Temple Fay, medical director, Neuro-Physical Rehabilitation Clinic, Philadelphia.

Marjorie Fish, director of training courses in occupational therapy, Columbia University, New York City.

Esther Hutchinson, physical therapist, Ohio State Department of Education, Columbus.

Dr. Christine Ingram, director of special education, public schools, Rochester, N. Y.

Carol Jensen, consultant on education of the physically handicapped, California State Department of Education, Sacramento.

Dr. Elise Martens, consultant in special education, United States Office of Education, Washington, D. C.

Manon McGinnis, psychiatric social worker, Children's Hospital, Boston.

Henrietta McNary, director, school of occupational therapy, Downer College, Milwaukee.

Dr. Edith Meyer, psychologist, Children's Hospital, Boston.

Dr. Veronica O'Brien, medical director, cerebral-palsy unit, Neurological Institute, New York City.

Dr. Myer Perlstein, medical director, Mandel Clinic, Michael Reese Hospital, Chicago.

Helen Porteus, social-service department, Michael Reese Hospital, Chicago.

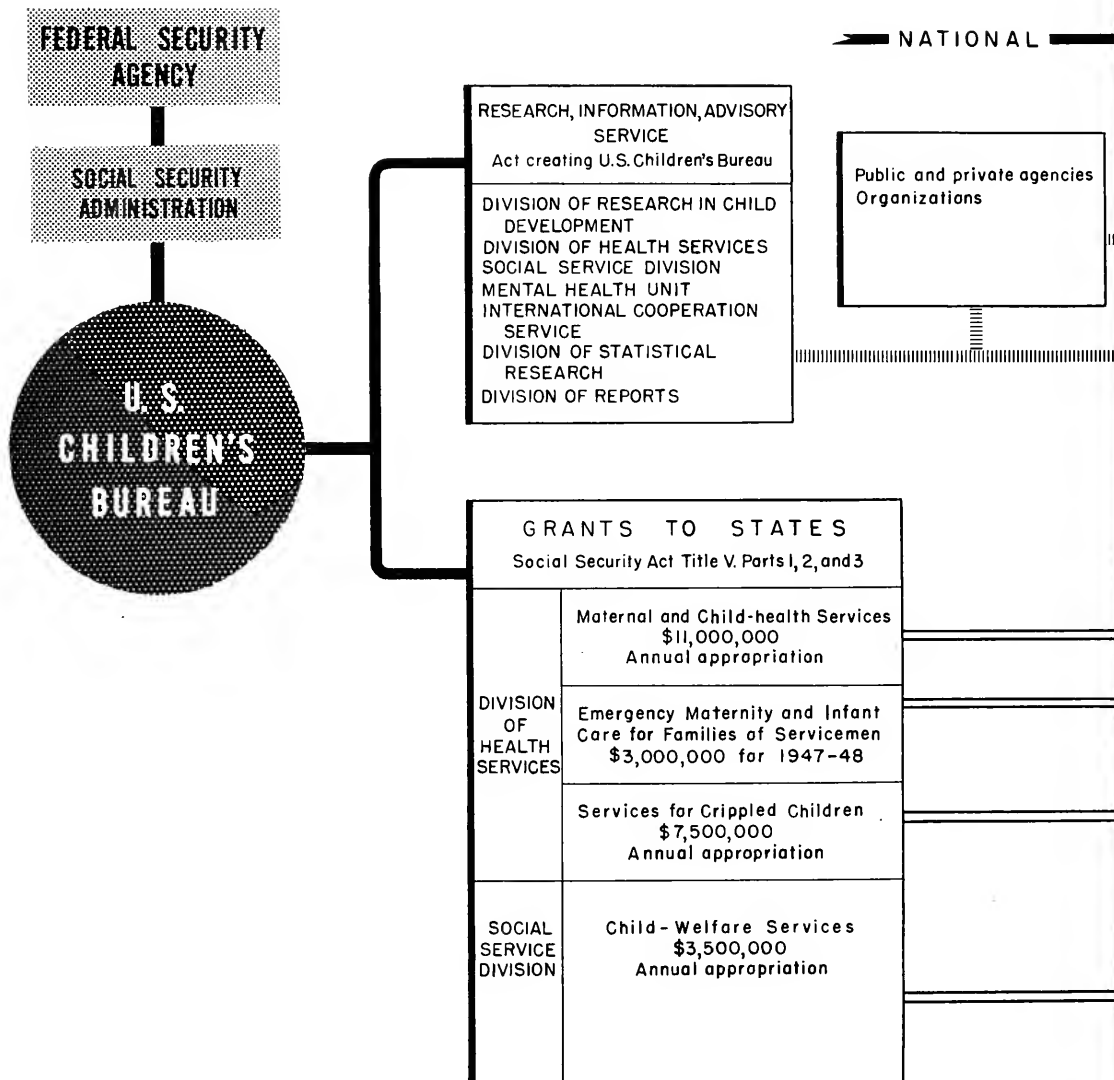
Clare S. Spackman, assistant director, Philadelphia School of Occupational Therapy, Philadelphia.

Dr. L. E. Wiley, professor of psychology, Beloit College, Beloit, Wis.

Grace Woolfenden, supervising principal, schools for crippled children, Oakman School, Detroit.

Reprints available in about 5 weeks

HOW U. S. CHILDREN'S BUREAU SERVES

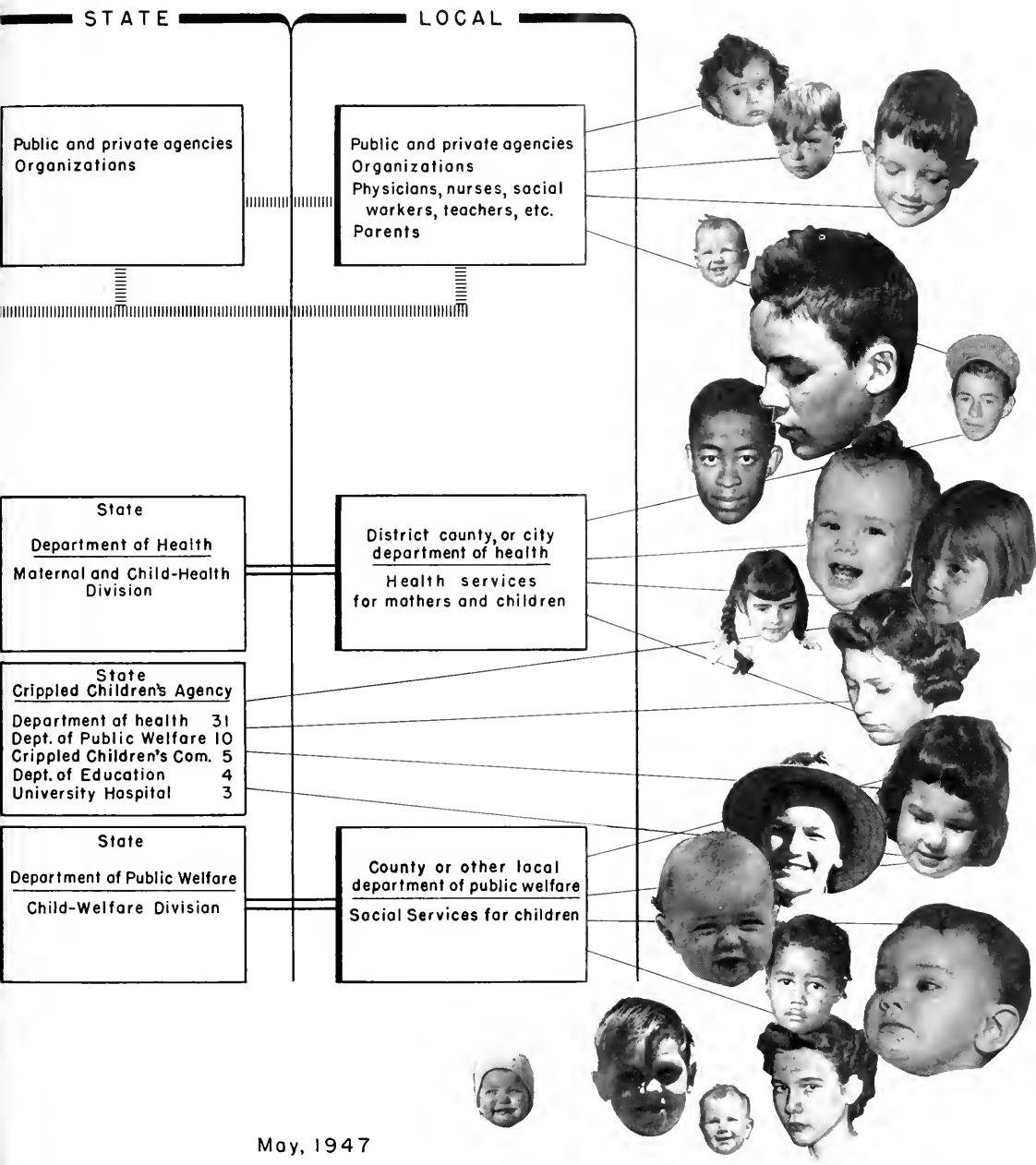


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ES REACH CHILDREN



WHAT THE BIRTH RECORD MEANS FOR A CHILD

HELEN C. HUFFMAN, *Social Science Analyst,*

National Office of Vital Statistics, U. S. Public Health Service

"THE PURPOSE of a birth certificate ain't to prove that you've been born—but when, where at, and who to." That's the way Will Rogers put it. And for most people the birth certificate is just that. For thousands of people it serves as necessary proof of age, of citizenship, and of relationship to other members of a family. Sometimes, however, the birth record is also a public announcement of a person's illegitimacy; of his "bad blood," because his mother had syphilis; or of his "criminal tendencies," because his father was in a penitentiary at the time of his birth.

Social implications of photostatic certified copies

Through the years the content of the birth certificate has grown from a few legal items to include about 50 items of information needed for medical and statistical purposes. Had vital statisticians known a generation ago that some five million copies of birth certificates would now be issued annually, they could have planned better. They might have foreseen what would happen when the complete record is placed in anybody's hands. They could have designed the certificate so that it could be reproduced in sections. A photostat could then be made of the parts a person needs for a particular purpose and nothing more. Medical and statistical data could have been placed in a confidential supplement, which would never appear on a certified copy.

Just what is it about birth records that causes trouble? It is not the birth certificate itself. Every item on it is valuable to the child. The difficulty comes with the practice of photostating the entire record as the certified copy. Because the whole record is given out, millions of people who use the birth record for proof of age, citizenship, and parentage, receive with this proof all

the other facts on the record—facts which were never intended for public view. These facts, in the various States, may include information about complications of pregnancy and delivery, mother's test for syphilis, crippling conditions of the infant, and illegitimacy.

All birth records contain private information. It is simply not the business of the general public that you are the fifteenth child or that your mother had six still-born babies, or that you were born during the seventh month of her pregnancy.

Birth records affect the lives of people in an endless variety of ways. I was in a State registration office when a young man requested his birth record. When he looked at the photostatic copy he was quick to express his protests. He said that a few months earlier, he had been offered a responsible position, which he planned to accept, but at the last minute the offer was withdrawn without explanation. Now he realized that in the investigation of his fitness the employer must have obtained a copy of his certificate. The entry on the birth record for "Occupation of father" was answered, "In an insane asylum." The fact was that the father was the chief psychiatrist in a hospital for mental illnesses, not a patient.

In this case the harm done to the young man was due to an error in the birth certificate, but it would not have happened if the registrar's office were not following the practice of giving out a certified copy of the whole certificate whenever any of the recorded information is needed.

Now that the war demand for birth certificates is over, there is time once again to plan. We cannot go back and undo the harm that was done to many

Condensed from paper given at the National Conference of Social Work, San Francisco, April 13-19.

thousands of people by unnecessary revealing of information that was on their birth certificates. But we can now help to bring about better methods of issuing certified copies of birth records all over the country. We can also improve our birth-registration programs so as to make the record do its job as the link between the child and the service he needs.

Who are the children needing help?

Who are these children who can be helped by a universally good birth-registration program?

They are the babies whose births do not get registered at all, many of whom are in need of nursing and medical care. Public health agencies are ready to give this care if only they know of the babies' existence.

They are the babies with crippling conditions at birth who do not become known to their State crippled children's agency.

They are the children born out of wedlock, and the mothers of these children, whose personal affairs become public knowledge through loose handling of the baby's birth record.

They are the legitimated children whose original records were falsified by misguided mothers, attendants, and social workers, children who cannot obtain a correct birth record without going into court and revealing the whole story.

They are the adopted children for whom nobody took the time to file a certificate showing the facts as they existed at the time of birth—children who go through life feeling a great need to know who were their natural parents.

They are the children entering school whose birth record sets them apart from their playmates because it shows they were born out of wedlock. Do you know that one State actually issues white birth records to legitimate children for school entrance and orange-colored records to children registered as illegitimate? Think what this means to the child with the orange-colored certificate.

A few years ago many States issued for the child born out of wedlock a certificate that isolated him as distinctly as does the orange-colored certificate in the State just mentioned. Fortunately today there are only a few States

that permit this type of discrimination. Birth registration has come a long way, but it still has a long way to go. In each State we find some good practices, and there is no reason why these cannot become the common practice in all the States. If only we could all get together and pool our experience, every child in the country could realize the maximum benefit from his birth record.

A hypothetical State program

By bringing together techniques from a State here and a State there, we can construct a hypothetical model State to see how a good registration program would operate. We can imagine a baby born in the State of X, and follow his birth certificate to see what it means to him.

Because many States prepare certified copies of birth records by means of a picture process, the format of the record assumes importance. The certificate could be arranged so that the legal items of name and date and place of birth could be placed at the top of the form. As a second portion, information about the parents could be entered. Then, in a confidential part of the record, the doctor could enter the numerous items of important statistical and health information. The question of legitimacy or illegitimacy would also be placed in this confidential part. The certified copy could then be made by taking a picture of only the first section when a person needs proof of birth place

and birth date. The second portion could be included in the picture when a person needs proof of parentage. The confidential information would never be given into public hands.

Here is the course that the birth certificate follows in the hypothetical State. The physician or midwife attending the birth completes the record and mails it to the local registrar, who may or may not be a member of the staff of the local health department. When the local registrar receives it, his job is to look after the validity of the record as a legal document. He passes the certificate on to the local health officer, who uses the record primarily as a medical document. The local health officer then sends it to the State health department, where the registrar uses it as a statistical document and thereafter safeguards it as the child's best proof of birth date, citizenship, and parentage.

Birth record confidential

At each of these steps the welfare of the child is considered. In the hands of the local registrar, the birth record becomes confidential. He refuses to release any information for advertising purposes. He refuses to permit the town busybody or any credit company to see it. Backing him up is a law which specifies that access to the record can be given to no one except authorized agencies. He makes sure there is nothing on the nonconfidential part of the record which would be detrimental to

the child if it appeared on his certified copy. "Occupation" of father and mother are reviewed to be sure that these entries give only the usual occupations and do not mention that a parent is in a penitentiary or in a hospital for mental diseases. He makes sure that the result of the mother's test for syphilis is not shown on the legal part of the record, and that the word "illegitimate" or "bastard" is not written across the face of the record. But, you say, it is obvious that birth records should not contain statements of this kind. Yet in one State today the law still requires the doctor who attends an unmarried mother to write "illegitimate" across the face of the certificate of the baby.

In the hands of the local health officer (still in State X) the record is carefully reviewed for health purposes.

If the record shows that the baby was delivered by a midwife or that the mother was not seen by a physician during pregnancy, or if the record suggests that nursing care may be needed, a nurse visits the home and explains to the mother the need for medical care for herself and her baby and tells her about the postnatal and well-baby clinics.

If the nurse finds a need for case work or financial help, she gets in touch with the welfare office. Any crippling condition (such as clubfoot, cleft palate, or harelip) reported on the record is referred immediately to the crippled child

This mother is giving the doctor who delivered her some information needed for the baby's birth certificate. It is the doctor's duty to fill in the certificate and send it to the registrar.



After the health department received this baby's birth certificate, a member of the staff told the mother about the well-baby clinic, and invited her to bring her baby to it.



dren's service. Corrective measures can then be begun at the time when correction can be most effective. If the record shows that the attendant at birth failed to use a prophylactic drug in the baby's eyes or that the mother had not been given a test for syphilis, the health officer gets in touch with the attendant.

If a midwife attended the birth and she is not enrolled in training classes, she is told why she must attend classes or stop practicing.

The record is checked with the registrar of rheumatic-fever cases known to the health department. If the mother has a history of rheumatic fever this fact will be kept in mind, and the baby will be followed through his early life and school years to be sure that he receives special periodic examinations.

The record is also checked with the venereal-disease and tuberculosis registers. If the mother or father is known to have syphilis or tuberculosis the baby will be followed up so that he can be given special tests for as long a time as the physician considers necessary.

An immunization card is made, so that the mother can be notified at the proper times for having the baby immunized against diphtheria, whooping cough, tetanus, and smallpox. The certificate is then forwarded to the State health department of our State X.

Time for the twins' vaccination against whooping cough, the public-health nurse reminds the mother at one of her visits. As this family's home is away up in the hills, the nurse first heard of the twins through their birth certificates.



In the State office of vital statistics, the registrar makes a photostatic picture of the certificate and sends it to the mother. Accompanying the picture is a form on which she can request the correction of any mistakes.

Mistakes *do* happen! Sometimes they happen in ways that nobody could foresee. I once had a visit from an irate father who came to me about an entry on a birth certificate. It seems that when the child was born a hospital employee stepped into the waiting room of the maternity hospital, saw a man pacing back and forth, and asked his name, occupation and age. She failed to ask him if he were the father of the child. It developed that the father was away and his uncle went with the mother to the hospital. If the mother had not had an opportunity to review the record, it is possible that this mistake might have remained for a long time and caused the child considerable embarrassment at some future day.

A program composed of the best practices from all the States would have special procedures for a child born out of wedlock.

The registrar would write to the mother and explain that if the baby's father is willing to have his name appear on the certificate as the father, he may send in a signed statement to this effect. The registrar would also explain to the mother that if she and the baby's father marry each other at any time in the future, they may send in a copy of the marriage certificate and the father's acknowledgment of paternity. These documents would be matched with the original record and filed away, and thereafter could be seen only on court order. A new certificate would be prepared, showing that the child's parents were married to each other.

The certificate would then be passed on to the statistician. In his hands the facts of birth are converted into symbols and punched into a card. The punched card for the baby is run through tabulating machines with the cards of all the other babies born in the State. The totals are studied along with those obtained from death and stillbirth records and with population figures.

With this information year after year, public authorities can predict with reasonable accuracy what will

happen to our population. School officials can tell how many children will be going to school 6 years from now. City planning commissioners can determine where housing projects are needed most. Health officials learn what kinds of clinics and hospitals are needed and where they should be placed.

Information on the number of children born with crippling conditions and the types of such conditions provides a basis for planning services for crippled children according to their needs.

Social-welfare groups can find out where to place recreational facilities and will know the relative sizes of the groups that they must consider by age and sex.

Vital statistics needed

The uses of vital statistics are endless. During the war a Government official sent to the National Office of Vital Statistics a frantic request for estimates of the number of babies who would be born in each State during the following 6 months. He explained that he must have the information in order to decide how many diapers the manufacturers should make and where they should be distributed. He said that the number of babies far exceeded the limited supply of diapers on hand, and, he concluded, "the situation in many parts of the country today is very wet."

Turning again to a program made up of the best in registration, we see that safeguards must be taken to document and protect the legal records of adopted children. In States having sound registration programs, parents adopting a child can look to the registrar to obtain from the court a report of the adoption. They can be assured that the registrar will link this report with the original birth certificate of the child, carefully seal the two documents away from public view, and prepare a new birth certificate on which the baby is shown to be their legitimate child.

Let us suppose that our child is now a young man and needs proof of age and citizenship from his birth record to present to his employer. Let us suppose that his record contains some bit of information which might affect his chance of getting the job. In a good State program the registrar no longer

(Continued on p. 206)

COUNCIL PREPARES FOR NINTH PAN AMERICAN CHILD CONGRESS

ELISABETH SHIRLEY ENOCHS, *Director,*
Inter-American Cooperation Service

ON APRIL 25, official representatives of 12 of the 18 member countries attended the regular annual meeting of the International Council (or governing body) of the American International Institute for the Protection of Childhood, in Montevideo, Uruguay.

Plans for the Ninth Pan American Child Congress, which is to be held in Caracas, Venezuela, January 5-10, 1948, occupied a prominent place on the agenda. The Council approved the suggestion made in accordance with a recommendation of the Eighth Congress that the next regular meeting of the Council be held in the host city of the Ninth Congress, dividing its meeting into two sessions, one a day or two in advance of the opening of the Congress, and one after its adjournment, in order to take whatever action may be necessary on the resolutions to be adopted on that occasion.

Election of officers for the 2-year period 1947-49 resulted in the reelection of Dr. Gregorio Arazo Alfaro, noted Argentine pediatrician, who has presided over the Council since the foundation of the Institute; of the Secretary, Dr. Víctor Escardó y Anaya, of Uruguay, who has held this office since 1927; and of the Director, Dr. Roberto Berro, who succeeded the Institute's founder, Dr. Luis Morquio, in the death of the latter in 1935.

For the first time since its creation 20 years ago, the Institute this year elected a vice president, Katharine F. Lenroot, Chief of the United States Children's Bureau, who has been the official representative of the United States on the Council since this country, by joint resolution of Congress, became a member of the Institute in 1928.

In the official communication addressed to her by the other officers of the Council, following the meeting, it was stated that this action of the Council was "in recognition of her intelligent devotion to child welfare, to the unflinching steadfastness with which she has

participated in the work of the Institute, and in recognition of the moral support given us on all occasions by the country which she has represented in this organization."

Prior commitments had made it impossible for Miss Lenroot to attend the Council meeting. The United States was represented by the writer, as alternate for Miss Lenroot, and by the resident delegate in Montevideo, Edward J. Sparks, Counselor of Embassy, and Chargé d'Affaires of the United States during the present absence of an American Ambassador to Uruguay. The statutes of the organization provide that each member country may have two representatives, a technical delegate and a resident delegate; that is to say, a representative residing in Montevideo, either a diplomat or some other qualified person, who can carry on relations with the Institute between meetings of the Council and represent the technical delegate if the latter is unable either to travel to Montevideo or to send an alternate.

In 1943 the Council voted to establish three technical departments—of health, education, and social service. The health department, under the direction of Dr. Víctor Escardó y Anaya, has been most active. After making a survey of rheumatic fever on the American continent, the results of which were published in the quarterly bulletin, the Institute sought to make notification of this disease compulsory. A resolution to this effect was approved by the recent Ninth Pan American Sanitary Conference, and the Institute was informed by the Paraguayan delegate to the Council meeting that his country is the first to issue a decree putting this recommendation into effect. The Ecuadorean delegate reported that similar action is about to be taken in his country.

Of special interest to the delegates from the United States was the report on the assistance given by the Institute to our Department of State in making new Spanish translations of three bulle-

tins of the Children's Bureau: "Prenatal Care," "Infant Care," and "Your Child From One to Six." Under a contract entered into between the Institute and the Central Translating Division of the Department of State, the Institute engaged three competent translators to translate the new, revised English editions. The Director and Secretary of the Institute gave their time to supervision and revision of the work of the translators, and the manuscripts of the Spanish texts were sent by air mail to the Institute's representatives in the other American Republics for the checking of terms which, because of the wide variations found between the different American countries, cause expressions familiar to every mother in Central America to be almost unintelligible to a mother in the Andean countries or those on the River Plate. Upon return of the manuscripts the Institute compiled a glossary of these varied terms, which will be a feature of each of the three bulletins in its new Spanish version.

The Institute took special note of the action of the General Assembly of the United Nations in creating the International Children's Emergency Fund and voted to communicate with the Secretariat of UN, expressing its interest in this mark of concern for child welfare, and inquiring as to the possibility of designating someone to represent it as an observer, in order to keep adequately informed concerning projects of the world organization in the field of child welfare.

Definite plans are being made by the Director General of the Institute, Dr. Roberto Berro, to attend the Ninth International Conference of American States when it meets in Bogotá, Colombia, in December 1947, to review the Inter-American system of which the Institute has now been a part for 20 years. Meantime strong efforts are being made to activate the Institute's departments of education and social service, which have been held back by financial limitations (the new system of quotas adopted last year gives signs of helping this situation) and to secure adherence of the three nonmember countries (Haiti, Nicaragua, and Panama) before the Institute's twentieth birthday on June 9.

issues photostatic pictures as the usual certified copy. Instead, birth cards are issued.

The birth card, showing name, sex, birth date, and birthplace, is a pocket-sized certification, sealed in plastic. It was developed by the Council of the American Association of Registration Executives. One of the major purposes of the birth card is to provide a certification that omits unnecessary statements and at the same time is identical in format for all people. (For further discussion of the birth card see *The Child* for August 1946.)

We have traced some of the major benefits a child can receive from his birth record. These are not utopian dreams. They are practical realities in a few of the States today. Many civic groups have been aware of bad registration practices in their communities, but they did not know where to turn to find out what would be better. Fortunately this handicap no longer exists. The National Office of Vital Statistics, United States Public Health Service, Federal Security Agency, Washington, D. C., has collected a wealth of information on the laws and procedures and practices of all the States, and now has this information in usable form. Small groups of interested citizens have in the past few years worked to improve birth registration, and have realized most gratifying results.

Looking at the over-all field of child care, we realize that almost all community health or welfare projects can use to great advantage the birth, death, and stillbirth registrations. The registrar's office cuts across nearly every field of child care. His office provides one of the basic tools of every health program. Children in any State will not fare very well until the registration program is sound through and through. To do the total job well, persons interested in the welfare of children should assist the registrar in his efforts to bring his program in line with the best practices to be found anywhere in the country. By working together for a few years, we can transplant our so-called model program from this paper to 48 actual States.

Reprints available in about 5 weeks

Great Friend of Children Retires From Active Life

The Child cannot fail to take note of the retirement from active work last February of Homer Folks, for 54 years Secretary of the New York State Charities Aid Association.

Mr. Folks, the year after he became the executive of that pioneering agency, secured the approval of the association for the establishment of an agency for aiding homeless mothers to care for their children; and 4 years later the association inaugurated both a child-placing and adoption service and a program of helping counties to establish county agencies for dependent children—the forerunner of the modern public child-welfare service programs in county welfare departments. In 1902 Mr. Folks' historical study, "The Care of Destitute, Neglected, and Dependent Children," was published, and for many years remained the standard work in this field.

To the Children's Bureau, Mr. Folks' part in the movement leading to its establishment, his continuing inspiration and helpful counsel through the years, and particularly his part in three of the four decennial White House Conferences on children, make him a very special friend and associate. Mr. Folks was appointed by President Theodore Roosevelt as vice-chairman and presiding officer of the first White House Conference on Dependent Children, in 1909. His overseas service after the first World War made it impossible for him to participate in the second White House Conference, but in 1929 and 1930 he was chairman of the committee on dependent and neglected children, of the White House Conference on Child Health and Protection. He took a leading part in the organization and work of the 1940 White House Conference on Children in a Democracy as a vice-chairman of the National Citizens' Committee, set up to carry on follow-up activities.

Of the four White House Conferences, in a 1940 paper entitled, "Four Milestones of Progress," Mr. Folks said: "Each Conference exerted a direct and powerful influence on child welfare."

Mr. Folks' kindly humor and the outreach of his imagination are illustrated by his speech at the preliminary session of the 1940 White House Conference.

"In planning for this 1939 Conference," he said, "we have been looking ahead, not to 1940, but to 1980, or thereabouts. Somewhere within these United States, within the past few years, was born a child who will be elected in 1980 to the most responsible office in the world. . . . We cannot guess his name or whereabouts. He may come from any

place and from any social or economic group. He may now be in the home of one of the soft-coal miners, or in the family of a share-cropper, or quite possibly in the home of one of the unemployed . . . or he may be surrounded by every facility, convenience, and protection that money can buy. Very likely his home is on a farm . . .

"If we could unroll the scroll of the future enough to know his name and whereabouts, how many things we would wish to have done for him, how carefully we would wish to guard his health, his surroundings, his associates, his travels, his ambitions—and what a gorgeous mess we almost certainly would make of it. . . .

"Since we cannot know his name or address, we have only one opportunity to see that the President of the United States in 1980 will be prepared for his job. We must decide what are the major needs of all children who are to become useful, competent, public-spirited citizens. We must, seriously and without delay, see that all the needful steps are taken, and that these minimum provisions are made available for all the children of the United States—for every last one."

The staff of the Children's Bureau rejoices that they can continue to look to Mr. Folks for counsel and encouragement.

Katharine F. Lenroot

Dr. Eliot Chairman of U. S. Delegation to Health Congress in England

Resuming a series of annual meetings, halted by World War II, the Health Congress of the Royal Sanitary Institute met at Torquay, England, June 2-6. Dr. Martha M. Eliot, Associate Chief of the Children's Bureau, served as chairman of the United States delegation.

Mental-Health Radio Programs Available

"For These We Speak" is the title of an electrically transcribed series of eight radio plays dealing with various aspects of mental illness. Organizations desiring to assist in the sponsorship of this series over radio stations in their communities may address their inquiries to the Radio Section of the National Mental Health Foundation, Box 7574, Philadelphia 1.

YOUR COMMUNITY: its provision for health, education, safety, and welfare, by Joanna C. Colcord. Russell Sage Foundation, New York, 1947. 263 pp.

Since 1911 the Russell Sage Foundation has been publishing guides for community self-analysis, revising them and producing a new one from time to time as changes in world conditions have affected community emphasis on various social problems. "Your Community: its provisions for health, education, safety, and welfare" has been revised recently by Donald S. Howard, Director of the Department of Social Work Administration, Russell Sage Foundation, to meet the requirements of the new developments in many fields, particularly of housing, medical care, consumer protection, and public assistance. The new emphases range over such varying interests as rural dwellings, migrant and seasonal workers, and interfaith and interchurch cooperation.

CHILDREN AND LITERATURE.

Bulletin of the Association for Childhood Education, 1201 Sixteenth Street NW., Washington 6.

Novel ways of bringing children and books together are pointed out by workers whose original ideas will undoubtedly serve as the stimulating force behind many new projects. Warning: Such enthusiasm is catching.

REPORT OF THE COMMITTEE ON THE JUVENILE EMPLOYMENT SERVICE. Ministry of Labor and National Service. His Majesty's Stationery Office, London, 1945. 63 pp.

Great Britain's Committee on the Juvenile Employment Service, which included representatives of national and local governments as well as labor, industry, and education groups, recommends that the employment service should give vocational guidance to all boys and girls before they leave school and to all who are still in school when they reach the age of 17.

The committee emphasizes the importance of having the employment service receive from the school a complete and confidential record for each pupil; not merely a formal statement of school attainments, but an account of the young person's special aptitudes, interests, personal qualities, home circumstances, health—to assist the employment service in giving the right guid-

ance. It suggests also that supplementary verbal information from the teacher, the parents, and sometimes from a social agency may be helpful.

Many suggestions are given in the report for encouraging young people to look to the juvenile-employment office for friendly advice.

PUBLIC HEALTH AND WELFARE ORGANIZATION IN CANADA, by Harry M. Cassidy. The Ryerson Press, Toronto, 1945. 464 pp.

This book, a sequel to the author's "Social Security and Reconstruction in Canada," published in 1943, was written before the Canadian Parliament had authorized a national system of family allowances and the establishment of a Federal department of health and welfare.

The discussion of the principles involved in the reorganization of Canadian health and welfare services is pertinent to problems faced in many of our own programs. The author takes up the need for well-trained personnel and for provincial responsibility for setting standards and supervising local activities financed wholly or partly from provincial funds. He mentions also the desirability of variable grants to enable local units to meet their health and welfare obligations.

Discussing the advantages and disadvantages of combined or separate departments of health and welfare and the appropriate functions of each department, Dr. Cassidy concludes that preventive health services and public medical-care programs, including mental hygiene, are the function of a department of public health; and public assistance, child welfare, vocational rehabilitation, and probation and parole, of a department of public welfare.

Margaret S. Skillman

NURSING AND NURSING EDUCATION, by Agnes Gelinas, R. N. Fifth monograph in the series, Studies of the New York Academy of Medicine Committee on Medicine and the Changing Order. Commonwealth Fund, New York, 1946. 72 pp. \$1.

Miss Gelinas points out candidly the reasons for the dissatisfaction of the public with the present methods of nursing care: the relationships of supply and demand during World War II; and

the uneven distribution of nursing care for low-income groups. She refers very briefly to coverage of various groups through medical- and hospital-insurance plans.

Students of nursing were better qualified in 1945 than in earlier years, says the author, through the cooperative efforts of high-school counselors; the raising of requirements for entrance to schools of nursing; the wider use of psychological tests; improved curricula; expanded clinical facilities; and improved methods of accrediting schools. She lists the outstanding problems that remain to be attacked, such as organization and financial support; pre-nursing requirements and selection of candidates; improvement in teaching personnel and clinical facilities; increasing importance of guidance and placement programs; the use of auxiliary workers; and continuing and advanced education.

Lucile A. Perozzi, R. N.

CONFERENCE CALENDAR

June 17-20—National Tuberculosis Association. Forty-third annual meeting. San Francisco.

June 23-26—American Home Economics Association. Thirty-eighth annual meeting. St. Louis.

June 23-28—General Federation of Women's Clubs. Annual convention. New York.

July 6-12—American Physiotherapy Association. Twenty-fourth annual meeting. Asilomar, Calif.

July 9-13—First Pan American Congress of Pediatrics. Washington.

July 14-17—Fifth International Congress of Pediatrics. New York. This international congress was to have been held in Boston in 1940, but had to be postponed because of the war. Further information from the secretary, Dr. L. Emmett Holt, Jr., Bellevue Hospital, New York 16.

Aug. 4-8—American Dental Association. Boston.

Schoolgirls on our June cover are enjoying a ball game on their playground. Photograph by Federal Housing Authority.

Other credits:

Pages 194 and 197, photographs by Manning Bros. for Michigan State Normal College, Ypsilanti.

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FOR THE CHILDREN OF ALL THE AMERICAS

June 9, 1947, marks the twentieth anniversary of the founding of the American International Institute for the Protection of Childhood, with headquarters at Montevideo, Uruguay. Through this great center of research and information, the American Republics share with one another their experience and progress in providing for the health, the welfare, and the education of their children and youth.

It would be impossible to review the accomplishments of the Institute without paying tribute to that great Uruguayan pediatrician, Dr. Luis Morquio, physician, teacher, and friend of children, whose vision and dynamic leadership inspired the resolutions of the Pan American Child Congresses that brought the Institute into being. The fact that the statue erected to the memory of Dr. Morquio stands in the park in front of the American Embassy in Montevideo has always seemed to me particularly symbolical of the close cooperation that exists between the Institute and the Children's Bureau of the United States. As Chief of this Bureau, and as the technical representative of the United States in the International Council of the Institute since the United States, by action of our Congress, became a member, I am deeply grateful for the privilege of having been associated with its development and for the opportunity that has been afforded

through the Institute for closer cooperation with the individuals and agencies in other American countries who are responsible for the health and welfare of children.

In his proclamation of Pan American Week, President Truman emphasized the fact that the inspiration and example furnished by the peaceful collaboration of the American Republics have contributed to the development of world-wide international cooperation through the United Nations for the welfare and security of all people everywhere. As we enter into a new era of international cooperation through the United Nations and its various specialized agencies, we have much to learn from the history and organization of the American International Institute for the Protection of Childhood.

As the president of the Eighth Pan American Child Congress, which met in Washington during the war period, in May 1942, I was deeply grateful to the Institute for its work in developing plans for the Congress, in reporting its results, and in supporting its resolutions and recommendations.

As a representative of one of the countries that are members of the Institute, I am grateful for the important contributions of the Institute to scientific knowledge about child health and welfare as evidenced by the special studies of nutrition, rheumatic fever, and poliomyelitis, made by the health department of the Institute, under the able direction of Dr. Victor Escardó y Anaya, and I am happy that the Inter-

American Cooperation Service of the United States Children's Bureau, in its program of cooperation with the American Republics, carried out under the auspices of the Interdepartmental Committee on Scientific and Cultural Cooperation of the Department of State, has had the constant support of the Institute in this work.

Just as President Truman's proclamation points out that "The Inter-American system that has developed around the Pan American Union will be further strengthened at the Ninth International Conference of American States, to be held in Bogotá, Colombia, in December of this year," let us hope that the cooperation of the American nations on behalf of their children will be further strengthened at the Ninth Pan American Child Congress, to be held in Caracas, Venezuela, in January 1948, and that when our official delegates assemble on that important occasion, every one of the 21 American Republics will be fully represented.

It is in this spirit of gratitude for association between the United States Children's Bureau and with the Institute in the past and of happy anticipation of even closer ties in the future that I send greetings to the American International Institute for the Protection of Childhood on its twentieth birthday.

Katharine F. Lenroot
KATHARINE F. LENROOT,
Chief,
United States Children's Bureau.

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UNITED STATES CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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Social Statistics

SUPPLEMENT TO VOLUME 11 OF THE CHILD (NOVEMBER 1946 SUPPLEMENT)

Juvenile-Court Statistics, 1944 and 1945

FEDERAL SECURITY AGENCY
SOCIAL SECURITY ADMINISTRATION
U. S. CHILDREN'S BUREAU

JUVENILE-COURT STATISTICS FOR 1944

THE YEAR 1944 is the eighteenth successive calendar year for which the U. S. Children's Bureau has collected statistics on delinquency cases disposed of by juvenile courts. During these 18 years there have been some changes from year to year in the courts making these reports, and fluctuations in the number of courts reporting, but in general the coverage of these statistics has grown from about 15 percent of the population of the United States in 1927 to 37 percent in 1944.

Nine-tenths of the courts reporting in 1944 reported under State plans, that is, reported to State agencies concerned with juvenile-court work or probation service, which then forwarded the data to the Children's Bureau; the other courts reported direct to the Bureau. The courts reporting under State plans served the greater part of the population served by all courts reporting in 1944. The nine States in which the courts reported in this way were Connecticut, Massachusetts, Missouri, New York, Rhode Island, and Utah, all with State-wide coverage, and Indiana, Ohio, and Texas, with partial coverage.

PLAN OF PRESENTATION OF MATERIAL

The statistical material in this report is presented in three sections, each dealing with data for a particular group of the reporting courts:

1. *Cases disposed of in 1944.*—Reports on juvenile-delinquency cases disposed of during 1944 were received for 380 juvenile courts. Data obtained from these reports are presented in tables 1 to 6. Table 1 shows (according to the races of the children involved) the number of cases disposed of by each of the courts serving areas with populations of 100,000 or more; for the courts that served areas with smaller populations, consolidated data are given for the States in which the courts are located. To assist in the interpretation of the statistics, the ages under which the courts have jurisdiction and the coverage of the reports with respect to both official and unofficial cases are shown in table 1. Tables 2 to 6 present in summary form for the 380 courts an analysis of the data, according to ages of the children involved, reasons for

referral to court, sources of referral, places of detention care, and dispositions of cases. (Source tables for juvenile-court statistics, similar to those published in some earlier reports, have been compiled for 1944 and are available for reference at the Children's Bureau. These source tables give, for individual courts, the data that are summarized in tables 2 to 6.)

2. *Decrease in cases, 1943 to 1944.*—Of the 380 courts reporting in 1944, 369 had made reports in 1943. There is shown in a text table the percent change from 1943 to 1944, in the number of cases disposed of, for these 369 courts, for those courts that served areas with populations of 100,000 or more, and for those that served areas with smaller populations.

3. *Trends in volume of cases, 1938 to 1944.*—Of the 380 courts reporting in 1944, 78 courts serving areas with populations of 100,000 or more had made reports for each year since 1938. Table 7 and figure 1 show the trends in volume of delinquency cases disposed of by these 78 courts during the years 1938 through 1944—years that included the prewar period as well as the war years.

DELINQUENCY CASES DISPOSED OF IN 1944

During 1944, 118,626 delinquency cases were disposed of by the 380 juvenile courts that participated voluntarily in the Children's Bureau juvenile-court-statistics project. Although these participating courts are not representative of all the areas in the country, analysis of the statistics on the delinquency cases disposed of by these courts makes possible some general observations on the volume of work of juvenile courts and on the characteristics of the children dealt with.

Sex and race

Of the 118,626 delinquency cases disposed of in 1944, 81 percent were boys' cases and 19 percent were girls' cases—table 1. The ratio of girls' cases to boys' cases was at a higher level from 1942 to 1944 than in previous years.

Of the cases for which the reports included the races of the children, white children were involved in 79 percent, Negro and other nonwhite

children in 21 percent. Regional differences in attitudes toward types of behavior manifested by children of the different racial groups and differences in community provisions for dealing with children of various racial groups have a marked effect on the number of children of each group referred to juvenile courts. Statistics on racial distribution, therefore, can be used most effectively for evaluative and planning purposes in local communities where due consideration can be given to community organization for handling delinquency and to prevalent attitudes on the treatment of children from different population groups.

Ages

Of the cases for which the ages of the children were reported, the greatest concentration—36 percent of the boys' cases and 45 percent of the girls' cases—occurred, as in previous years, in the 14-and-15-year age group—table 2. In 4 percent of the cases the children were under 10 years of age.

The maximum ages of juvenile-court jurisdictions, which in only a few instances extend to persons who have reached their eighteenth birthdays, affect to a great extent the age distribution of cases handled by the courts. Of the 380 courts reporting in 1944, 65 had original jurisdiction in delinquency cases of children under 16 years of age; 192, of children under 17 years of age; 112, under 18 years; and 6, under 21 years. In addition, the 2 courts in Oklahoma had original jurisdiction in delinquency cases of boys under 16 and of girls under 18, and the 3 Texas courts had original jurisdiction in delinquency cases of boys under 17 and of girls under 18.

Reasons for referral to court

The reasons for which boys were most commonly referred to courts differed considerably from those for which girls were most commonly referred—table 3. In 40 percent of the boys' cases for which the reasons for referral were reported, the referrals were for types of stealing (including automobile stealing, burglary or unlawful entry, robbery, and all other types of stealing), and in 20 percent

they were for acts of carelessness or mischief. Among girls' cases, three types of behavior—being ungovernable, running away, and sex offenses—accounted for 60 percent of the cases for which the reasons for referral were reported.

The proportion of all girls' cases that were referred to reporting courts for these three types of behavior was lower in 1944 than at any time since 1939, when it was also 60 percent; in 1941 it was as high as 64 percent. These three reasons are considered together because ungovernable behavior and running away frequently involve sex offenses; moreover, some courts use the term ungovernable behavior to avoid recording sex offenses for girls on official records. However, it should not be assumed that all cases of running away or ungovernable behavior involve sex offenses.

Sources of referral to court

Children are referred to juvenile courts not only by the police but by parents or other relatives, by other individuals, by school authorities, and by social agencies. Analysis of these

sources of referral indicates to some extent the relations of the courts to other community agencies, the effects of community pressures on the work of the courts, and the prevailing community attitudes on the role of the court. For example, the frequency with which cases are referred to courts by parents, relatives, individuals, and social agencies reflects the extent to which the juvenile court is called on to deal with behavior problems other than those coming to the attention of the police—either because there are no other community resources for services to children or because it is felt that the court is the best resource in a particular situation.

The sources of referral to court in the cases for which this information was reported are shown in *table 4*. Almost three-fourths (74 percent) of the boys' cases were referred by the police; only one-half of the girls' cases were referred by this source. In four of the urban areas (Dallas, Hennepin, Milwaukee, and Ramsey Counties) the police referred three-fourths or more of the girls' cases. Parents or other relatives referred only 4 percent of the

boys' cases, as compared with 17 percent of the girls' cases. In only one of the urban areas (New York City) were 10 percent or more of the boys' cases referred by parents or relatives.

The differences in the sources of referral of boys' cases and of girls' cases may be explained in part by the fact that the largest proportion of the boys' cases were referred for stealing, a type of behavior that is more likely to come to the attention of the police, while in girls' cases two of the principal reasons for referral were being ungovernable and running away, conduct more likely to be referred to court by parents or other relatives.

The proportion of cases referred by each source varies from court to court, but in general the statistics show that social agencies do refer a small proportion of the delinquency cases that come to court. The importance of social agencies in dealing with delinquency problems should not be minimized, however, inasmuch as the small number of referrals to court by these agencies may indicate that they are handling without referral the problems of children that come to their attention.

Table 1.—Juvenile-delinquency cases, 1944: Boys' and girls' cases, by race, disposed of by 89 courts serving areas with populations of 100,000 or more and by 291 courts serving areas with populations of less than 100,000¹

Location of areas served by courts and chief cities in certain areas	Age under which court has original jurisdiction ²	Data include unofficial cases?	Juvenile-delinquency cases								
			All races			White ³		Negro and other nonwhite		Race not reported	
			Total	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
Total cases.....			118,626	95,827	22,799	63,351	15,164	15,965	4,331	16,511	3,304
AREAS WITH 100,000 OR MORE POPULATION.....			105,105	81,951	20,154	56,637	13,322	15,435	4,169	12,879	2,663
Arkansas											
Pulaski County (Little Rock).....	21	Yes.....	855	506	352	274	251	232	101		
California											
Los Angeles County (Los Angeles)..... ⁴	21	No.....	4,108	3,459	649	3,154	566	305	83		
San Diego County (San Diego).....	21	Yes.....	2,141	1,589	552	1,495	519	89	33	5	
San Francisco—city and county.....	21	No.....	815	566	249	499	226	55	22	12	1
Connecticut											
First district (Bridgeport).....	16	Yes.....	1,647	1,416	231	1,307	187	109	44		
Second district (New Haven).....	16	Yes.....	1,690	1,392	298	1,277	265	115	33		
Third district (Hartford).....	16	Yes.....	1,710	1,410	300	1,307	253	103	47		
District of Columbia											
Washington—city.....	18	Yes.....	3,171	2,770	401	1,279	112	1,491	289		
Florida											
Dade County (Miami).....	17	No.....	992	685	307					685	307
Georgia											
Fulton County (Atlanta).....	16	Yes.....	1,376	1,122	254					1,122	254
Indiana											
Allen County (Fort Wayne).....	18	Yes.....	633	492	141	461	128	31	13		
Lake County (Gary).....	18	Yes.....	461	314	147	252	122	62	25		
Marion County (Indianapolis).....	18	Yes.....	1,948	1,307	641	1,067	316	140	125		
St. Joseph County (South Bend).....	18	Yes.....	1,324	970	354	861	323	106	31		
Vanderburgh County (Evansville).....	18	Yes.....	680	536	144	470	125	66	19		
Iowa											
Polk County (Des Moines).....	21	Yes.....	764	654	110	554	99	100	11		
Woodbury County (Sioux City).....	21	Yes.....	506	371	135	351	131	20	4		
Louisiana											
Caddo Parish (Shreveport).....	17	Yes.....	855	639	216	500	149	139	67		
Massachusetts											
Boston											
Boston (central section).....	17	No.....	711	496	215					496	215
Brighton.....	17	No.....	47	40	7					40	7
Charlestown.....	17	No.....	69	52	17					52	17
Dorchester.....	17	No.....	235	220	15					220	15
East Boston.....	17	No.....	156	112	44					112	44
Roxbury.....	17	No.....	928	538	390					538	390
South Boston.....	17	No.....	117	108	9					108	9
West Roxbury.....	17	No.....	155	144	11					144	11
Central district of Worcester (Worcester).....	17	No.....	450	398	52					398	52

See footnotes at end of table.

Table 1.—Juvenile delinquency cases, 1944: Boys' and girls' cases, by race, disposed of by 89 courts serving areas with populations of 100,000 or more and by 291 courts serving areas with populations of less than 100,000—Continued

Location of areas served by courts and chief cities in certain areas	Age under which court has original jurisdiction ²	Data include unofficial cases?	Juvenile delinquency cases								Race not reported	
			All races			White ³		Negro and other nonwhite				
			Total	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	
Massachusetts—Continued												
East Norfolk district (Quincy).....	17	No.....	315	292	23	.....	.....	.....	.....	292	23	
First district of eastern Middlesex (Medford).....	17	No.....	277	213	41	.....	.....	.....	.....	213	41	
Lawrence district (Lawrence).....	17	No.....	101	87	14	.....	.....	.....	.....	87	14	
Lowell district (Lowell).....	17	No.....	82	73	9	.....	.....	.....	.....	73	9	
Second district of Bristol (Fall River).....	17	No.....	163	141	22	.....	.....	.....	.....	141	22	
Somerville district (Somerville).....	17	No.....	111	100	11	.....	.....	.....	.....	100	11	
Southern Essex district (Lynn).....	17	No.....	148	140	8	.....	.....	.....	.....	140	8	
Springfield district (Springfield).....	17	No.....	241	191	50	.....	.....	.....	.....	191	50	
Third district of Bristol (New Bedford).....	17	No.....	235	218	17	.....	.....	.....	.....	218	17	
Third district of eastern Middlesex (Cambridge).....	17	No.....	300	257	43	.....	.....	.....	.....	257	43	
Michigan												
Kent County (Grand Rapids).....	17	No.....	505	430	75	418	71	12	4	.....	.....
Wayne County (Detroit).....	17	No.....	2,430	1,982	468	1,425	335	557	133	.....	.....
Minnesota												
Hennepin County (Minneapolis) ⁵	18	No.....	1,270	914	356	873	342	39	13	.....	2	1
Ramsey County (St. Paul).....	18	No.....	684	563	121	538	108	25	13	.....	.....
Missouri												
Jackson County (Kansas City).....	17	Yes.....	1,858	1,403	455	1,129	389	272	66	.....	.....
St. Louis—city.....	17	Yes.....	1,827	1,215	612	753	378	445	215	2	17	19
St. Louis County (University City).....	17	Yes.....	492	422	70	344	62	78	8	.....	.....
New Jersey												
Hudson County (Jersey City).....	16	No.....	423	361	62	.....	.....	.....	.....	361	62	
Union County (Elizabeth).....	16	No.....	263	226	37	.....	.....	.....	.....	226	37	
New York												
Albany County (Albany).....	16	No.....	253	205	48	.....	.....	.....	.....	205	48	
Bronx County (Bronxhampton).....	16	No.....	110	84	26	.....	.....	.....	.....	84	26	
Chautauque County (Jamestown).....	16	No.....	158	136	22	.....	.....	.....	.....	136	22	
Dutchess County (Poughkeepsie).....	16	No.....	82	66	16	.....	.....	.....	.....	66	16	
Erie County (Buffalo).....	16	No.....	710	710	127	.....	.....	.....	.....	710	127	
Monroe County (Rochester).....	16	No.....	218	162	56	.....	.....	.....	.....	162	56	
Nassau County (Hempstead).....	16	No.....	213	184	29	.....	.....	.....	.....	184	29	
New York—city.....	16	No.....	6,965	5,622	1,043	3,615	618	2,007	425	.....	.....
Niagara County (Niagara Falls).....	16	No.....	254	178	76	.....	.....	.....	.....	178	76	
Oneida County (Utica).....	16	No.....	191	144	47	.....	.....	.....	.....	144	47	
Onondaga County (Syracuse).....	16	No.....	343	280	63	.....	.....	.....	.....	280	63	
Orange County (Newburgh).....	16	No.....	90	71	19	.....	.....	.....	.....	71	19	
Rensselaer County (Troy).....	16	No.....	226	170	56	.....	.....	.....	.....	170	56	
Schenectady County (Schenectady).....	16	No.....	188	159	29	.....	.....	.....	.....	159	29	
Suffolk County (Patchogue).....	16	No.....	86	73	13	.....	.....	.....	.....	73	13	
Westchester County (Yonkers).....	16	No.....	360	310	50	.....	.....	.....	.....	310	50	
Ohio												
Butler County (Hamilton City).....	18	Yes.....	989	742	247	682	216	58	31	2	.....
Cuyahoga County (Cleveland).....	18	Yes.....	3,760	2,823	937	2,065	621	723	301	35	15	
Franklin County (Columbus).....	18	Yes.....	1,179	798	381	586	312	198	68	14	1	
Hamilton County (Cincinnati).....	18	Yes.....	3,825	3,037	788	2,339	660	693	178	5	.....
Lorain County (Elyria).....	18	Yes.....	364	257	107	227	95	29	12	1	.....
Madison County (Youngstown).....	18	Yes.....	1,582	1,318	264	1,003	161	313	103	2	.....
Montgomery County (Dayton).....	18	Yes.....	1,513	1,454	59	1,171	286	71	27	1	2	
Stark County (Canton).....	18	Yes.....	82	82	30	72	9	1	1	.....	.....
Summit County (Akron).....	18	Yes.....	1,942	1,628	304	1,464	253	173	51	.....	.....
Trumbull County (Warren).....	18	Yes.....	474	386	88	330	71	55	16	1	.....
Oklahoma												
Tulsa—city.....	16, 18	Yes.....	1,245	837	408	693	339	144	69	.....	.....
Oregon												
Multnomah County (Portland).....	18	Yes.....	3,205	2,800	405	.....	.....	.....	.....	2,800	405	
Pennsylvania												
Allegheny County (Pittsburgh).....	18	No.....	3,238	2,557	681	1,939	453	618	228	.....	.....
Berks County (Reading).....	18	No.....	220	196	24	182	23	14	1	.....	.....
Montgomery County (Norristown).....	18	No.....	297	270	27	229	19	41	8	.....	.....
Philadelphia—city and county.....	18	Yes.....	9,395	7,959	1,436	4,336	764	3,623	672	.....	.....
Rhode Island												
State (Providence) ⁶	18	No.....	1,047	869	148	868	134	31	14	.....	.....
South Carolina												
Greenville County (Greenville).....	16	Yes.....	433	336	97	241	64	95	33	.....	.....
Texas												
Bexar County (San Antonio).....	17, 18	Yes.....	2,658	1,926	732	1,761	636	165	96	.....	.....
Dallas County (Dallas).....	17, 18	Yes.....	2,382	1,855	527	1,309	312	546	215	.....	.....
Utah²												
First district (Ogden).....	18	Yes.....	1,627	1,431	196	1,408	193	23	3	.....	.....
Second district (Salt Lake City).....	18	Yes.....	2,472	2,123	349	2,110	346	13	2	.....	.....
Third district (Provo).....	18	Yes.....	1,681	1,436	245	1,432	243	4	2	.....	.....
Virginia												
Norfolk—city.....	18	No.....	1,316	970	346	558	247	412	99	.....	.....
Washington												
Pierce County (Tacoma).....	18	Yes.....	440	350	90	.....	.....	.....	.....	350	90	
Spokane County (Spokane).....	18	Yes.....	546	407	139	.....	.....	.....	.....	407	139	
Wisconsin												
Milwaukee County (Milwaukee).....	18	Yes.....	6,617	5,726	891	5,426	820	300	71	.....	.....
AREAS WITH LESS THAN 100,000 POPULATION			13,621	10,876	2,645	6,714	1,842	530	162	3,632	641	
Indiana: 33 courts.....	18	Yes.....	1,928	1,414	514	1,357	477	57	37	.....	.....
Massachusetts: 54 courts.....	17	No.....	2,024	1,829	195	.....	.....	.....	.....	1,829	195	
Missouri: 112 courts.....	17	No.....	1,780	1,422	358	1,321	331	63	19	.....	.....
Montana: Yellowstone County.....	18	Yes.....	495	391	94	391	168	4	1	.....	.....
New York: 42 courts.....	16	No.....	1,628	1,333	295	.....	.....	.....	.....	1,333	295	
Ohio: 45 courts.....	18	Yes.....	3,965	3,149	816	2,915	750	181	43	.....	.....
Oklahoma: Tulsa County—exclusive of city.....	16, 18	Yes.....	232	164	71	153	71	8	.....	.....	.....
Texas: Wichita County.....	17, 18	Yes.....	499	379	120	.....	.....	.....	.....	379	120	
Utah: Fourth district⁷.....	18	Yes.....	368	326	42	.....	.....	.....	.....	326	42	
Virginia: Danville—city.....	18	No.....	602	472	130	255	68	217	62	.....	.....

¹ Population according to 1940 census.

² Where age under which court has original jurisdiction is different for boys and for girls, the age for boys appears first.

³ Includes all Mexicans.

⁴ For uniformity in reporting, data for this court include cases of truancy and incorrigibility with delinquency, although the court does not consider these as delinquency cases.

⁵ Excludes traffic violations.

⁶ Juvenile courts in New Jersey have authority to adjudicate cases involving adolescent offenders (between ages of 16 and 18 years) charged with indictable offenses if certified by prosecutor of pleas or other specified authorities.

⁷ Children's courts in New York State have jurisdiction over children up to 18 years of age in cases involving violation of the Education Law.

⁸ Before the juvenile-court reorganization in July 1944 this area was composed of 12 districts. In July 1944 the age under which the juvenile court in Rhode Island has jurisdiction over delinquent children was raised from 16 to 18 years.

⁹ Reported by State totals; break-downs for individual districts are estimated.

Places of detention care

The places in which children are cared for overnight or longer, pending hearing or disposition of their cases, and the extent of the care given them are dependent in part on the facilities available in local communities and in part on community attitudes on the need for detention. In some localities children brought to court in delinquency cases are detained for almost all types of offenses, whereas in others only certain types of delinquency are considered serious enough to warrant detention care.

Desirable standards of juvenile-court work require that children shall never be detained in jails or police stations. They should be allowed to remain in their own homes unless home conditions make immediate removal necessary, or unless the children are so far beyond the

control of their parents or guardians that there is danger of repetition of behavior menacing to themselves or to their communities, or unless detention is the only way that the children's presence in court can be assured. If detention is deemed necessary, suitable facilities other than jails or police stations should be used. These standards are widely accepted in principle, as is evidenced by legal restrictions placed on most juvenile courts against detaining children in jails or police stations; yet in practice extensive use of improper facilities for detention continues to be reported—*table 5*.

Delinquent children were detained overnight or longer pending hearing or disposition of their cases in 33,809 of the 77,859 cases for which information on detention care was reported. In 25 percent of these 33,809 cases the children

were detained at least part of the time in jails or police stations. The place of detention care most frequently reported for both boys' and girls' cases was a detention home; the reported use of boarding homes for detention care was negligible.

Disposition of cases

The disposition of cases by the various courts depends on the practices of the courts and on the availability of facilities for court supervision, for institutional care of children needing such service, or for other services to children.

The disposition most frequently made in 1944 in both boys' and girls' cases was "dismissed, adjusted, or held open without further action"—*table 6*. This disposition was made in 46 percent of the boys' cases and in 35 percent of the

Table 2.—Juvenile-delinquency cases, 1944: Ages of boys and of girls when referred to court, in cases disposed of by 380 courts

Age of child when referred to court	Juvenile-delinquency cases					
	Number			Percent		
	Total	Boys	Girls	Total	Boys	Girls
Total cases.....	118,626	95,827	22,799	.....	.....	.....
Age reported.....	107,508	86,724	20,784	100	100	100
Under 10 years.....	4,411	3,730	411	4	4	2
10 years, under 12.....	7,779	6,395	784	7	8	4
12 years, under 14.....	17,802	14,734	3,148	17	17	15
14 years, under 16.....	40,581	31,304	9,277	38	36	45
16 years and over.....	37,115	29,951	7,164	34	35	34
Age not reported.....	11,118	9,103	2,015	.....	.....	.....

Table 3.—Juvenile-delinquency cases, 1944: Reasons for reference to court, in boys' and in girls' cases disposed of by 380 courts

Reason for reference to court	Juvenile-delinquency cases					
	Number			Percent		
	Total	Boys	Girls	Total	Boys	Girls
Total cases.....	118,626	95,827	22,799	.....	.....	.....
Reason for reference reported.....	109,068	88,027	21,041	100	100	100
Stealing.....	37,217	33,035	2,182	34	40	10
Act of carelessness or mischief.....	19,120	17,858	1,262	18	20	6
Traffic violation.....	8,736	8,564	172	8	10	1
Truancy.....	9,226	6,352	2,874	8	7	14
Running away.....	9,688	5,419	4,269	9	6	20
Being unmanageable.....	9,833	5,236	4,617	9	5	22
Sex offense.....	6,433	2,681	3,752	6	3	18
Injury to person.....	3,299	2,855	444	3	3	2
Other reason.....	8,505	4,027	4,478	8	5	7
Reason for reference not reported.....	9,558	7,800	1,758	.....	.....	.....

Table 4.—Juvenile-delinquency cases, 1944: Sources of reference to court, in boys' and in girls' cases disposed of by 380 courts

Source of reference to court	Juvenile-delinquency cases					
	Number			Percent		
	Total	Boys	Girls	Total	Boys	Girls
Total cases.....	118,626	95,827	22,799	.....	.....	.....
Source of reference reported.....	94,314	75,915	18,429	100	100	100
Police.....	65,478	56,309	9,169	69	74	50
School department.....	7,186	5,089	2,097	8	7	13
Probation officer.....	2,685	1,335	1,350	3	2	4
Other court.....	1,088	1,368	320	2	2	2
Social agency.....	1,643	681	962	2	1	5
Parents or relatives.....	6,392	3,099	3,293	7	4	17
Other individual.....	7,812	6,573	1,239	8	9	7
Other source.....	1,190	861	329	1	1	2
Source of reference not reported.....	24,282	19,912	4,370	.....	.....	.....

Table 5.—Juvenile-delinquency cases, 1944: Places of detention care of boys and of girls, in cases disposed of by 380 courts

Place of detention care	Juvenile-delinquency cases					
	Number			Percent		
	Total	Boys	Girls	Total	Boys	Girls
Total cases.....	118,626	95,827	22,799	.....	.....	.....
Detention care reported.....	77,859	62,364	15,495	100	100	100
No detention care overnight.....	44,650	36,363	7,687	57	58	50
Detention care overnight or longer.....	33,809	26,001	7,808	43	42	50
Boarding home.....	132	82	50	()	()	()
Detention home.....	23,010	17,254	5,778	29	28	37
Other institution.....	715	460	253	1	1	2
Jail or police station.....	8,616	7,211	1,405	11	11	9
Other place of care.....	503	355	149	1	1	1
Place of care not reported.....	812	639	173	1	1	1
Detention care not reported.....	40,767	33,463	7,304	.....	.....	.....

¹ Less than 0.5 percent.

² Includes cases of children cared for part of the time in detention homes and part of the time elsewhere but excludes cases of children also cared for in jails or police stations.

³ Includes cases of children cared for part of the time in jails or police stations and part of the time elsewhere.

⁴ Includes cases of children cared for in more than one place but in places other than detention homes, jails, or police stations.

girls' cases for which disposition was reported. The high proportion of dismissals, especially in boys' cases, may mean that many children are being brought into court needlessly or that they need services other than those the courts are equipped to provide. In approximately one-third of both boys' and girls' cases the children were placed under the supervision of probation officers. Of the boys' cases, 8 percent were disposed of by commitment or referral to an institution, and 3 percent by commitment or referral to an agency or individual. The differences between the dispositions in boys' cases and those in girls' cases may be attributed partly to differences in the types of behavior for which boys and girls were most frequently referred to court. (See section REASON FOR REFERRAL TO COURT.)

DECREASE IN CASES, 1943 TO 1944

Of the 380 courts reporting on delinquency cases disposed of in 1944, 369 had reported also in 1943. The number of cases disposed of by these 369

courts decreased from 1943 to 1944, to the following extent:

Percent decrease, 1943 to 1944, in cases disposed of—	All cases	Boys' cases	Girls' cases
By 369 courts	5	5	4
By 78 courts serving areas with populations of 100,000 or more	4	4	3
By 281 courts serving areas with populations of less than 100,000	12	12	10

It will be noted that both in boys' cases and in girls' cases the percent de-

crease was greater for the courts serving areas with populations of less than 100,000 than for the courts serving areas with larger populations.

During the war period, when year-to-year increases were noted in the number of delinquency cases disposed of by reporting courts, the increases were not as marked for courts serving areas with

Table 6.—Juvenile-delinquency cases, 1944: Dispositions of boys' and of girls' cases, disposed of by 380 courts

Disposition of case	Juvenile-delinquency cases					
	Number			Percent		
	Total	Boys	Girls	Total	Boys	Girls
Total cases	118,626	95,827	22,799	-----	-----	-----
Disposition reported	106,745	88,555	21,190	100	100	100
Case dismissed, adjusted, or held open without further action	47,910	40,556	7,354	44	46	35
Child supervised by probation officer	35,022	28,027	6,995	32	32	33
Child committed or referred to an institution	9,913	7,280	2,633	9	8	12
State institution for delinquent children	6,093	4,679	1,414	5	5	7
Other institution for delinquent children	2,881	1,969	912	3	2	4
Penal institution	173	167	6	(1)	(1)	(1)
Other institution	766	405	361	1	1	1
Child committed or referred to an agency or individual	4,308	2,669	1,639	4	3	8
Public department	1,202	741	461	1	1	2
Other agency or individual	3,106	1,928	1,178	3	2	6
Other disposition of case	12,592	10,023	2,569	11	11	12
Disposition not reported	8,881	7,272	1,609	-----	-----	-----

¹ Less than 0.5 percent.

Table 7.—Juvenile-delinquency cases, 1938-44: Number of cases disposed of by 78 courts serving areas with populations of 100,000 or more ¹

Location of areas served by courts and chief city in area	Population change (percent) ²	Juvenile-delinquency cases						
		1938	1939	1940	1941	1942	1943	1944
Total cases	-----	53,134	57,601	55,545	60,644	65,351	86,906	84,879
Arkansas	-----	-----	-----	-----	-----	-----	-----	-----
Pulaski County (Little Rock)	+6.2	701	858	644	888	859	981	858
California	-----	-----	-----	-----	-----	-----	-----	-----
Los Angeles County (Los Angeles) ³	+12.8	2,438	2,646	2,646	3,172	3,378	4,458	4,108
San Diego County (San Diego)	+42.9	2,045	2,102	2,235	1,304	1,709	1,805	2,141
San Francisco—city and county	+8.7	634	623	582	621	591	446	815
District of Columbia	-----	-----	-----	-----	-----	-----	-----	-----
Washington—city	+24.2	1,807	2,723	2,597	3,094	2,860	3,204	3,171
Florida	-----	-----	-----	-----	-----	-----	-----	-----
Dade County (Miami)	+10.0	816	573	670	640	635	823	992
Georgia	-----	-----	-----	-----	-----	-----	-----	-----
Fulton County (Atlanta)	+4.2	1,121	1,049	1,079	1,164	1,192	1,549	1,376
Indiana ⁴	-----	-----	-----	-----	-----	-----	-----	-----
Allen County (Fort Wayne)	+1.5	107	92	102	125	138	779	633
Lake County (Gary)	+4.1	244	247	227	312	417	472	461
Marion County (Indianapolis)	+7.3	617	425	424	807	1,358	2,019	1,948
St. Joseph County (South Bend)	+7.0	436	644	685	853	1,012	1,579	1,324
Vanderburgh County (Evansville)	+13.7	153	171	239	293	490	740	506
Iowa	-----	-----	-----	-----	-----	-----	-----	-----
Woodbury County (Sioux City) ⁵	+13.4	954	1,087	772	465	342	497	568
Louisiana	-----	-----	-----	-----	-----	-----	-----	-----
Cadiz Parish (Shreveport) ⁶	+7.0	281	280	360	358	319	436	383
Massachusetts	-----	-----	-----	-----	-----	-----	-----	-----
Boston	-----	-----	-----	-----	-----	-----	-----	-----
Boston (central section)	+5.1	544	372	385	454	526	835	711
Brighton	+5.1	36	38	46	41	60	59	47
Charlestown	+5.1	75	78	85	66	82	92	69
Dorchester	+5.1	197	140	182	111	134	154	235
East Boston	+5.1	258	267	262	296	166	180	156
Roxbury	+5.1	486	356	331	398	387	542	428
South Boston	+5.1	129	128	111	82	105	115	117
West Roxbury	+5.1	141	110	98	133	114	179	155
Central district of Worcester (Worcester)	+6.2	334	365	322	324	347	373	450
East—Norfolk district (Quincy)	+5.1	147	124	151	165	173	275	315
First district of eastern Middlesex (Medford)	+5.1	146	169	140	193	166	232	257
Lawrence district (Lawrence)	+5.1	70	79	71	100	118	73	101
Lowell district (Lowell)	+5.1	112	115	97	58	80	58	82
Second district of Bristol (Fall River)	+5.1	149	121	163	124	145	239	163
Somerville—district (Somerville)	+5.1	84	76	102	55	55	70	111
Southern Essex district (Lynn)	+5.1	118	111	81	112	128	146	148
Springfield district (Springfield)	+2.9	166	169	143	143	150	241	241
Third district of Bristol (New Bedford)	+5.1	215	212	140	170	213	269	213
Third district of eastern Middlesex (Cambridge)	+5.1	138	92	135	220	219	236	300
Michigan	-----	-----	-----	-----	-----	-----	-----	-----
Kent County (Grand Rapids)	+6.1	442	420	406	372	368	587	505
Wayne County (Detroit)	+8.0	1,854	1,885	2,060	2,220	2,196	2,736	2,450
Minnesota	-----	-----	-----	-----	-----	-----	-----	-----
Hennepin County (Minneapolis) ⁷	+2.2	964	919	860	932	985	1,277	1,270
Ramsey County (St. Paul)	+3.3	405	451	510	458	469	729	684

See footnotes at end of table.

Table 7.—Juvenile-delinquency cases, 1938-44: Number of cases disposed of by 78 courts serving areas with populations of 100,000 or more¹—Continued

Location of areas served by courts and chief city in area	Population change (percent) ²	Juvenile-delinquency cases						
		1938	1939	1940	1941	1942	1943	1944
Missouri								
Jackson County (Kansas City)	+1 7	974	1,181	966	1,200	1,414	1,801	1,858
New Jersey								
Hudson County (Jersey City) ¹⁰	-8.4	321	357	270	275	311	335	423
New York								
Albany County (Albany)	-5 0	269	333	298	295	282	304	253
Broome County (Binghamton)	-0 8	146	129	64	212	103	131	110
Chautauque County (Jamestown)	-7 9	167	128	129	217	176	159	158
Dutchess County (Poughkeepsie)	-5 3	44	75	72	65	83	114	82
Erie County (Buffalo)	-0 1	807	860	681	791	790	1,114	862
Monroe County (Rochester)	-1 5	149	160	177	150	153	234	218
Nassau County (Hempstead)	+1 3	179	169	156	197	162	271	213
New York—city	-9 9	4,591	5,395	3,920	1,409	4,800	6,414	6,665
Niagara County (Niagara Falls)	+1 1	78	105	119	121	190	241	254
Oneida County (Utica)	-0 9	228	169	208	208	254	327	191
Onondaga County (Syracuse)	-1 0	347	297	296	328	304	471	343
Orange County (Newburgh)	-0 5	13	57	71	64	83	131	90
Rensselaer County (Troy)	-8 1	237	225	225	177	307	198	226
Schenectady County (Schenectady)	+2 0	90	121	103	107	106	91	188
Suffolk County (Patchogue)	+1 2	72	81	118	116	74	112	86
Westchester County (Yonkers)	-8 6	252	365	284	293	345	427	360
Ohio								
Butler County (Hamilton City)	+2 6	831	978	757	702	983	1,103	989
Franklin County (Columbus)	+7 3	1,157	1,183	1,015	1,086	1,072	1,312	1,179
Hamilton County (Cincinnati)	+4 9	3,321	3,456	3,203	3,319	3,128	4,117	3,825
Lorain County (Ellettsburg)	-1 0	115	198	244	77	200	305	364
Montgomery County (Dayton)	+11 6	1,112	1,188	1,463	1,338	1,341	1,933	1,813
Stark County (Canton) ⁶	+5 4	113	160	127	42	90	91	96
Summit County (Akron)	+7 1	850	1,157	1,106	1,073	1,311	2,060	1,942
Trumbull County (Warren)	+2 8	373	247	293	260	367	492	474
Oklahoma								
Tulsa—city ^{6 11}	+10.3	191	194	97	147	159	340	282
Oregon								
Multnomah County (Portland)	+26.2	832	880	830	957	1,208	2,719	3,295
Pennsylvania¹²								
Allegheny County (Pittsburgh)	-6 3	1,493	1,841	2,612	2,663	2,709	3,165	3,298
Berk County (Reading)	-7 8	117	124	135	157	183	248	220
Montgomery County (Norristown)	-1 0	115	128	155	182	272	292	297
Philadelphia—city and county	+0 8	4,507	5,313	6,430	6,841	7,335	9,433	9,395
Rhode Island								
State (Providence) ¹³	-2 0	556	540	441	481	537	820	1,047
South Carolina								
Greenville County (Greenville)	+2 8	191	241	202	270	292	300	433
Utah¹⁴								
First district (Ogden)	+12 3	597	593	558	624	901	1,321	1,627
Second district (Salt Lake City)	+2 9	997	1,111	1,069	1,245	1,738	2,613	3,472
Third district (Provo)	+2 1	440	513	542	1,071	1,131	1,713	1,681
Virginia								
Norfolk—city	+50.8	833	679	484	646	785	1,182	1,316
Washington								
Pierce County (Tacoma)	+20 6	145	174	159	245	277	416	440
Spokane County (Spokane)	+6 0	511	512	481	559	503	1,065	546
Wisconsin								
Milwaukee County (Milwaukee)	-0 6	4,846	5,720	4,802	5,973	6,086	6,881	6,617

¹ Report includes courts, serving areas with populations of 100,000 or more according to 1940 census, for which data are available since 1938; for age jurisdictions of courts and indication whether data include unofficial cases, see table 1.

² Estimated percent change in civilian population, April 1, 1940, to November 1, 1943. Bureau of the Census. Population—Special Reports, Series P-44, No. 3 (Washington, February 15, 1944).

³ For uniformity of reporting, data for this court include cases of truancy and incorrigibility with delinquency, although the court does not consider these as delinquency cases.

⁴ In March 1941 the age under which juvenile courts in Indiana have jurisdiction over delinquent boys was raised from 16 to 18 years.

⁵ In July 1941 an amendment to the law authorized filing of petitions in juvenile courts in Iowa for any minor over 18 instead of only to 18 years of age.

⁶ Includes official cases only for all years shown, although data including modified cases are available for some years (see table 1, and previous reports).

⁷ Estimate based on population of whole metropolitan area in which court is located, not on population of area served by court; separate estimates for subdivisions are not available.

⁸ In March 1944 jurisdiction of juvenile courts in Michigan, formerly exclusive over children between ages of 17 and 21 years committing certain offenses, was made concurrent over children between ages of 17 and 19 committing such offenses.

⁹ Excludes traffic violations.

¹⁰ In April 1943 an amendment to the 1929 Juvenile Court Act gave juvenile courts in New Jersey authority to adjudicate cases involving adolescent offenders (between ages of 16 and 18 years) charged with indictable offenses if certified by prosecutor of pleas or other specified authorities.

¹¹ In May 1941 the age under which juvenile courts in Oklahoma have jurisdiction over delinquent girls was raised from 16 to 18 years.

¹² In September 1939 the age under which juvenile courts in Pennsylvania have jurisdiction over delinquent children was raised from 16 to 18 years.

¹³ Before the juvenile-court reorganization in July 1941 this area was composed of 12 districts. In July 1941 the age under which the juvenile court in Rhode Island has jurisdiction over delinquent children was raised from 16 to 18 years.

¹⁴ Before the juvenile-court reorganization in March 1942 the first district was composed of the first and second districts, the second district was designated as the third district, and the third district was composed of the fourth and seventh districts. ¹⁵ Estimated.

small populations as for those serving areas with populations of 100,000 or more. Migration of people from rural areas to industrial centers and the greater disruption of normal family life in those urban areas—because of housing shortages, employment of women, and strains on community services—may explain these greater increases in earlier years and the smaller decrease in 1944 for courts serving areas with populations of 100,000 or more. However, the data for the courts serving areas with smaller populations represent only 11 percent of the total number of cases reported for 1944 by the 369 courts.

TRENDS IN VOLUME OF CASES, 1938 TO 1944

Trends in the volume of delinquency cases disposed of from 1938 to 1944 are described here on the basis of reports from 78 courts serving areas with populations of 100,000 or more for which data are available for these 7 years—table 7 and figure 1. Though the number of cases disposed of by these 78 courts was slightly lower in 1944 than in 1943, there has been a substantial over-all increase since 1938, as is shown in table 8.

The decrease from 1943 to 1944 in the number of girls' cases was the first break in a progressive year-to-year increase that had been noted since 1939.

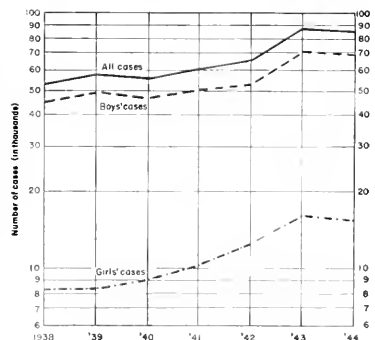


Figure 1.—Ratio chart: Juvenile-delinquency cases disposed of from 1938 to 1944 by 78 courts serving areas with populations of 100,000 or more.

The over-all increase between 1938 and 1944 was substantially greater for girls' cases than for boys' cases.

Changes in volume of juvenile-court cases, particularly during the war years, should be considered in relation to shifts in population with the attendant changes in the number of children subject to the jurisdiction of the various juvenile courts. The effect of population changes on volume of delinquency cases may be studied by comparing the number of cases disposed of in areas where the population increased with the number disposed of in areas where the population decreased. For the areas served by the 78 courts considered here, figures on population changes between 1940 and 1943 are available.¹ In the areas served by 36 of the courts the population increased; in the areas served by 42 courts it decreased. For both groups of courts there were increases between 1940 and

1944 in the number of delinquency cases disposed of. The percent increases were as follows:

Percent increase, 1940 to 1944, in cases disposed of—	All cases	Boys' cases	Girls' cases
By 36 courts serving areas where population increased.....	59	55	82
By 42 courts serving areas where population decreased.....	42	39	58

The greater increases in delinquency cases disposed of in the areas that gained in population may be the result not only of an increase in the number of children under juvenile-court jurisdiction in those areas but also of conditions such as overcrowding and inadequate educational and recreational

facilities that were found in most areas with war-swollen populations. The large increase (42 percent) from 1940 to 1944 in delinquency cases disposed of in the areas whose populations decreased indicates that factors related generally to the war contributed substantially to the increase in delinquency cases during that period. Some of these factors were the absence of one or both parents from home, shortages of trained personnel to deal with children's problems, wartime anxieties and strains, and unwholesome surroundings and associations of children in some types of employment.

Table 8.—Juvenile-delinquency cases, 1938-44: Changes from year to year in cases disposed of by 78 courts serving areas with populations of 100,000 or more

Year	Number disposed of			Percent change from preceding year			Percent change from 1938		
	All cases	Boys' cases	Girls' cases	All cases	Boys' cases	Girls' cases	All cases	Boys' cases	Girls' cases
1938.....	53,134	44,819	8,315	—	—	—	—	—	—
1939.....	57,601	49,223	8,378	+8	+10	+1	+8	+10	+1
1940.....	55,545	46,514	9,031	-4	-5	+7	+5	+4	+8
1941.....	60,614	50,329	10,315	+9	+8	+15	+14	+12	+24
1942.....	65,351	52,837	12,514	+8	+5	+21	+23	+18	+50
1943.....	80,906	70,784	16,122	+33	+34	+29	+64	+58	+94
1944.....	84,879	69,235	15,644	+2	-2	-3	+60	+54	+88

¹ *Estimated Civilian Population of the United States, by Counties: November 1, 1943.* Bureau of the Census: Population—Special Reports, Series P-44, No. 3 (Washington: February 15, 1944).

Limitations of Juvenile-Court Statistics

Statistics on juvenile-delinquency cases disposed of present a general picture of the volume of the work of juvenile courts in dealing with delinquent behavior. The number of cases reported by different courts is influenced greatly by variations in the administrative practices of the courts. Some courts report only cases that they have disposed of officially—that is, after the filing of legal papers necessary to have the cases placed on the court calendar. Other courts report, in addition, the cases disposed of unofficially—without formal action—by judges, probation officers, or referees. Some courts may handle certain types of cases as dependency or neglect cases whereas the same cases in other courts might be handled as delinquency cases.

Another factor affecting the number of delinquency cases reported (and thus affecting the comparability of the reports) is the age jurisdiction of the courts. The age limit for children coming under juvenile-court jurisdiction is established by State law and in most instances is uniform throughout a

State, though it varies from State to State as is shown in table 1. The data are influenced also by other factors such as the personnel and facilities of the courts, the relations of the courts to other agencies serving youth and to law-enforcement agencies in the communities, and the development of necessary community services for children.

Juvenile-court statistics as collected by the U. S. Children's Bureau refer to the number of cases disposed of by courts rather than to the number of children involved. One child may appear before the court two, three, or more times during the year, for the same reason or for different reasons, and each appearance is counted as another case if a new complaint is filed and dealt with separately. In planning a program of services directed toward the prevention and treatment of juvenile delinquency by community welfare agencies, it is important to know the number of children who are likely to need such services.

Statistics on delinquency cases disposed of by juvenile courts, even if they

were Nation-wide in coverage, would not truly indicate the volume of delinquent behavior in the United States as a whole, just as statistics on cases disposed of by an individual court are not an accurate indication of the volume of delinquency in the community served by that court. Many children whose behavior may be classed as delinquent are not represented in juvenile-court statistics, either because they are not apprehended or because they are dealt with by the police, social agencies, schools, public or private youth-serving agencies, or other resources in the community and are not referred to a court. For example, the decline between 1943 and 1944 in the number of cases disposed of by the St. Louis (city) court, 40 percent, and by the Polk County (Des Moines) court, 24 percent, reflect the effects of the establishment of juvenile divisions in the police departments that made it unnecessary for some children involved in delinquent behavior to appear in court. The extent to which situations of this sort obtain varies from city to city and often from year to year within the same city.

(Continued on page 11)

JUVENILE-COURT STATISTICS FOR 1945

REPORTS on the number of juvenile-delinquency cases disposed of during 1945 were received for 374 juvenile courts. The data obtained from these reports are presented in tables 1 to 6 and are comparable in form and content to those appearing in tables 1 to 6 for 1944. There were few changes in the courts reporting in 1945 as compared with 1944, and the number of courts from which reports were received differed only slightly from the preceding year.

Review of the data for 1945 indicates that there have been no marked changes from 1944 in the relative distribution for each of the factors analyzed (for example, age and reason for referral to court) and that the general observations on the 1944 data are applicable also to the data for 1945.

Of the 374 courts reporting on delinquency cases disposed of in 1945, 364 had reported also in 1944. The total number of delinquency cases disposed of by these 364 courts in 1945 was 6 percent higher than in 1944; the number of boys' cases was 8 percent higher and the number of girls' cases was 4 percent lower than in 1944. In girls' cases disposed of, the decrease (8 percent) for courts serving areas with populations of less than 100,000 was more pronounced than the decrease (3 percent) for courts serving areas with larger populations.

For 76 courts serving areas with populations of 100,000 or more, comparable data are available since 1938. For these 76 courts the decrease of 5

percent from 1944 to 1945 in the number of girls' cases continued the decrease noted from 1943 to 1944, which had interrupted a constant increase since 1939. The increase of 8 percent from 1944 to 1945 in the number of boys' cases, which comprise more than four-fifths of the total number of cases disposed of, reverses the decrease noted from 1943 to 1944 and continues the upward trend of the last several years.

The increase in the number of delinquency cases disposed of by juvenile courts in 1945 as compared with 1944 emphasizes the importance of strengthening programs of services for children. The end of the war should not lead to a relaxation of community efforts in this direction.

Table 1.—Juvenile-delinquency cases, 1945: Boys' and girls' cases, by race, disposed of by 88 courts serving areas with populations of 100,000 or more and by 286 courts serving areas with populations of less than 100,000¹

Location of areas served by courts and chief cities in certain areas	Age under which court has original jurisdiction?	Data include unofficial cases?	Juvenile-delinquency cases							
			All races		White		Negro and other nonwhite		Race not reported	
			Total	Boys	Girls	Boys	Girls	Boys	Girls	Boys
Total cases			122,851	101,240	21,611	57,124	12,222	15,802	3,966	28,314
AREAS WITH 100,000 OR MORE POPULATION			108,469	89,322	19,147	50,556	10,680	13,058	3,823	23,705
Arkansas										
Pulaski County (Little Rock)	21	Yes	1,447	754	693	376	312	408	141	
California										
Los Angeles County (Los Angeles)	21	No	4,604	3,887	717	3,276	462	305	78	306
San Diego County (San Diego)	21	Yes	2,034	1,567	466	1,484	437	83	29	
San Francisco—city and county	21	Yes	2,458	1,796	662	536	175	63	25	1,230
Connecticut										
First district (Bridgeport)	16	Yes	1,505	1,298	207	1,211	171	87	36	
Second district (New Haven)	16	Yes	1,398	1,379	219	1,290	182	119	37	
Third district (Hartford)	16	Yes	1,435	1,204	231	1,116	212	88	19	
District of Columbia										
Washington—city	18	Yes	3,202	2,806	396	1,205	126	1,801	270	
Georgia										
Fulton County (Atlanta)	16	Yes	1,597	1,299	298					1,299
Indiana										
Allen County (Fort Wayne)	18	Yes	613	505	108	463	97	42	11	
Lake County (Gary)	18	Yes	363	284	80	246	55	37	23	
Marion County (Indianapolis)	18	Yes	2,542	2,036	506	1,510	82	326	124	
St. Joseph County (South Bend)	18	Yes	1,617	1,284	333	1,174	281	130	52	
Vanderburgh County (Evansville)	18	Yes	808	678	130	635	115	84	15	
Iowa										
Polk County (Des Moines)	21	Yes	839	725	114	619	34	24	6	582
Woodbury County (Sioux City)	21	Yes	583	465	118					465
Louisiana										
Calder Parish (Shreveport)	17	Yes	671	543	128	432	79	111	49	
Massachusetts										
Boston:										
Boston (central section)	17	No	766	491	215					491
Brighton	17	No	49	48	1					48
Charlestown	17	No	87	82	5					82
Dorchester	17	No	176	163	13					163
East Boston	17	No	133	122	11					122
Roxbury	17	No	663	585	76					585
South Boston	17	No	168	152	16					152
West Roxbury	17	No	228	212	16					212
Central district of Worcester (Worcester)	17	No	464	432	32					432
East Norfolk district (Quincy)	17	No	208	220	18					220
First district of eastern Middlesex (Medford)	17	No	282	277	25					277
Lawrence district (Lawrence)	17	No	88	79	9					79
Lowell district (Lowell)	17	No	118	110	8					110

See footnotes at end of table.

Table 1.—Juvenile-delinquency cases, 1945: Boys' and girls' cases, by race, disposed of by 88 courts serving areas with populations of 100,000 or more and by 286 courts serving areas with populations of less than 100,000—Continued

Location of areas served by courts and chief cities in certain areas	Age under which court has original jurisdiction ²	Data include unofficial cases?	Juvenile-delinquency cases								
			All races			White ³		Negro and other nonwhite		Race not reported	
			Total	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
Massachusetts—Continued											
Second district of Bristol (Fall River).....	17	No.....	117	108	9	.....	.....	.....	.....	108	9
Somerville district (Somerville).....	17	No.....	113	104	9	.....	.....	.....	.....	104	9
Southern Essex district (Lynn).....	17	No.....	155	145	10	.....	.....	.....	.....	145	10
Springfield district (Springfield).....	17	No.....	291	248	43	.....	.....	.....	.....	248	43
Third district of Bristol (New Bedford).....	17	No.....	228	223	15	.....	.....	.....	.....	223	15
Third district of eastern Middlesex (Cambridge).....	17	No.....	333	300	33	.....	.....	.....	.....	300	33
Michigan											
Kent County (Grand Rapids).....	17	No.....	556	487	69	473	59	14	10	.....	.....
Wayne County (Detroit).....	17	No.....	1,990	1,606	384	1,219	280	387	104	.....	.....
Minnesota											
Hennepin County (Minneapolis).....	18	No.....	1,454	1,065	389	.....	.....	.....	.....	1,065	389
Ramsey County (St. Paul).....	18	No.....	632	512	120	502	116	10	4	.....	.....
Missouri											
Jackson County (Kansas City).....	17	Yes.....	2,105	1,600	505	1,329	432	269	72	2	1
St. Louis—city.....	17	Yes.....	1,671	1,107	564	740	329	356	224	11	11
St. Louis County (University City).....	17	Yes.....	477	406	71	361	50	45	21	.....	.....
New Jersey											
Hudson County (Jersey City).....	16	No.....	602	506	96	.....	.....	.....	.....	506	96
Union County (Elizabeth).....	16	No.....	231	193	38	.....	.....	.....	.....	193	38
New York											
Albany County (Albany).....	16	No.....	196	175	21	.....	.....	.....	.....	175	21
Broome County (Binghamton).....	16	No.....	142	115	27	.....	.....	.....	.....	115	27
Chautauqua County (Jamestown).....	16	No.....	138	130	8	.....	.....	.....	.....	130	8
Dutchess County (Poughkeepsie).....	16	No.....	90	71	15	.....	.....	.....	.....	71	15
Eric County (Buffalo).....	16	No.....	695	607	88	.....	.....	.....	.....	607	88
Monroe County (Rochester).....	16	No.....	305	261	44	.....	.....	.....	.....	261	44
Nassau County (Hempstead).....	16	No.....	288	268	20	.....	.....	.....	.....	268	20
New York—city.....	16	No.....	7,037	6,058	979	3,948	541	2,110	438	.....	.....
Niagara County (Niagara Falls).....	16	No.....	200	147	53	.....	.....	.....	.....	147	53
Oneida County (Utica).....	16	No.....	144	123	21	.....	.....	.....	.....	123	21
Onondaga County (Syracuse).....	16	No.....	436	384	52	.....	.....	.....	.....	384	52
Orange County (Newburgh).....	16	No.....	115	115	14	.....	.....	.....	.....	115	14
Rensselaer County (Troy).....	16	No.....	242	183	59	.....	.....	.....	.....	183	59
Schenectady County (Schenectady).....	16	No.....	153	126	27	.....	.....	.....	.....	126	27
Suffolk County (Patchogue).....	16	No.....	143	127	16	.....	.....	.....	.....	127	16
Westchester County (Yonkers).....	16	No.....	373	319	56	.....	.....	.....	.....	319	56
Ohio											
Butler County (Hamilton City).....	18	Yes.....	1,098	838	260	696	202	144	58	1	940
Cuyahoga County (Cleveland).....	18	Yes.....	4,208	3,328	940	.....	.....	.....	.....	3,328	940
Franklin County (Columbus).....	18	Yes.....	1,101	908	193	588	249	205	59	.....	.....
Hamilton County (Cincinnati).....	18	Yes.....	3,498	2,872	626	2,158	405	713	221	1	.....
Lorain County (Elyria).....	18	Yes.....	408	338	70	317	61	21	6	.....	.....
Lucas County (Toledo).....	18	Yes.....	1,173	933	240	778	213	145	57	.....	.....
Mahoning County (Youngstown).....	18	Yes.....	1,430	1,109	321	1,109	345	64	2	.....	2
Montgomery County (Dayton).....	18	Yes.....	1,857	1,542	315	1,235	241	298	74	9	.....
Stark County (Canton).....	18	No.....	179	152	27	127	26	25	1	.....	.....
Summit County (Akron).....	18	Yes.....	1,788	1,480	278	1,330	220	150	58	.....	.....
Trumbull County (Warren).....	18	Yes.....	586	522	64	475	56	47	8	.....	.....
Oklahoma											
Tulsa—city.....	16, 18	Yes ⁴	1,143	759	384	599	279	160	105	.....	.....
Oregon											
Multnomah County (Portland).....	18	Yes ⁵	9 (2,852)	.....	.....	.....	.....	.....	.....	.....	.....
Pennsylvania											
Allegheny County (Pittsburgh).....	18	No.....	3,417	2,740	677	2,145	462	595	215	.....	.....
Berks County (Reading).....	18	No.....	172	101	72	55	12	16	.....	90	.....
Montgomery County (Norristown).....	18	Yes.....	576	576	141	208	24	15	10	353	107
Philadelphia—city and county.....	18	Yes.....	9,652	8,252	1,400	4,583	749	3,669	651	.....	.....
Rhode Island											
State (Providence).....	18	No.....	1,960	1,692	268	1,572	248	120	20	.....	.....
South Carolina											
Greenville County (Greenville).....	16	Yes.....	340	270	70	167	30	103	40	.....	.....
Texas											
Bexar County (San Antonio).....	17, 18	Yes.....	2,932	2,275	657	2,102	592	173	65	.....	.....
Dallas County (Dallas).....	17, 18	Yes.....	2,263	1,707	556	1,244	383	463	173	.....	.....
Utah											
First district (Ogden).....	18	Yes.....	1,845	1,640	205	.....	.....	.....	.....	1,640	205
Second district (Salt Lake City).....	18	Yes.....	3,410	3,157	253	.....	.....	.....	.....	3,157	253
Third district (Provo).....	18	Yes.....	1,579	1,413	169	.....	.....	.....	.....	1,413	169
Virginia											
Norfolk—city.....	18	No.....	1,085	812	273	432	199	380	74	.....	.....
Washington											
Pierce County (Tacoma).....	18	Yes.....	490	376	114	.....	.....	.....	.....	376	114
Spokane County (Spokane).....	18	Yes.....	554	454	100	.....	.....	.....	.....	454	100
Wisconsin											
Milwaukee County (Milwaukee).....	18	Yes.....	6,583	5,691	892	5,417	796	274	96	.....	.....
AREAS WITH LESS THAN 100,000 POPULATION			14,382	11,918	2,464	6,566	1,542	744	173	4,606	749
Indiana: 34 courts.....											
Adams County.....	18	Yes.....	2,121	1,670	451	1,578	432	92	19	.....	.....
Louisiana: East Baton Rouge Parish.....	17	No.....	343	266	77	114	46	152	31	.....	.....
Massachusetts: 54 courts.....											
Barnstable County.....	17	No.....	2,259	2,042	217	.....	.....	.....	.....	2,042	217
Missouri: 112 courts.....											
Montgomery County.....	18	Yes.....	1,990	1,653	337	1,531	313	66	15	56	9
Montana: 4 courts.....											
Yellowstone County.....	18	Yes.....	400	331	69	324	65	7	.....	.....	.....
New York: 42 courts.....											
Albany County.....	16	No.....	1,545	1,288	257	.....	.....	.....	.....	1,288	257
Ohio: 58 courts.....											
Tulsa County—exclusive of city.....	16, 18	Yes ¹⁰	3,579	3,168	711	2,764	641	211	49	193	21
Oklahoma: Tulsa County.....											
Tulsa County—exclusive of city.....	16, 18	Yes.....	197	169	88	.....	.....	.....	.....	169	88
Texas: Wichita County.....											
Fourth district.....	18	Yes.....	487	371	116	.....	.....	.....	.....	371	116
Utah: 4 courts.....											
Davis County.....	18	No.....	573	473	100	257	45	216	55	547	41
Virginia: Danville—city.....											

¹ Population according to 1940 census.

² Where age under which court has original jurisdiction is different for boys and for girls, the age for boys appears first.

³ Includes all Mexicans.

⁴ For uniformity of reporting, data for this court include cases of truancy and incorrigibility with delinquency, although the court does not consider these as delinquency cases.

⁵ Data for official cases only, comparable to those reported in previous years, are as follows, for total cases, boys' cases, and girls' cases, respectively: California, San Francisco city and county—782, 571, and 211; Louisiana, Caldo Parish—369, 297, and 93; Oklahoma, Tulsa city—180, 130, and 50; Pennsylvania, Montgomery County—257, 223, and 34.

⁶ Excludes traffic violations; data are estimated.

⁷ Juvenile courts in New Jersey have authority to adjudicate cases involving adolescent offenders (between ages of 16 and 18 years) charged with indictable offenses if certified by prosecutor or other specified authorities.

⁸ Children's courts in New York State have jurisdiction over children up to 18 years of age in cases involving violation of the Education Law.

⁹ Data for Multnomah County, Ore., are not included in total cases for all courts inasmuch as the break-down by sex is not available.

¹⁰ Belmont County reported official cases only.

Table 2.—Juvenile-delinquency cases, 1945: Ages of boys and of girls when referred to court, in cases disposed of by 374 courts

Age of child when referred to court	Juvenile-delinquency cases					
	Number			Percent		
	Total	Boys	Girls	Total	Boys	Girls
Total cases	122,851	101,240	21,611			
Age reported	110,415	91,435	18,980	100	100	100
Under 10 years	4,172	3,703	469	4	4	2
10 years, under 12	8,032	7,311	721	7	8	4
12 years, under 14	18,362	15,558	2,804	17	17	13
14 years, under 16	40,872	32,645	8,227	37	36	43
16 years and over	38,977	32,178	6,799	35	35	36
Age not reported	12,436	9,805	2,631			

Table 3.—Juvenile-delinquency cases, 1945: Reasons for reference to court, in boys' and in girls' cases disposed of by 374 courts

Reason for reference to court	Juvenile-delinquency cases					
	Number			Percent		
	Total	Boys	Girls	Total	Boys	Girls
Total cases	122,851	101,240	21,611			
Reason for reference reported	111,939	92,671	19,268	100	100	100
Stealing	40,879	38,610	2,269	37	42	12
Act of carelessness or mischief	19,241	17,779	1,462	17	19	8
Traffic violation	9,852	9,659	193	9	10	1
Truancy	8,681	6,164	2,517	8	7	13
Running away	9,307	5,652	3,655	8	6	19
Being ungovernable	9,840	5,542	4,298	9	6	22
Sex offense	5,990	2,579	3,411	5	3	18
Injury to person	3,224	2,828	396	3	3	3
Other reason	4,925	3,858	1,067	4	4	5
Reason for reference not reported	10,912	8,569	2,343			

Limitations

(Continued from page 8)

Data on the number of delinquency cases disposed of include not merely the most serious offenses, but many types of alleged delinquency from the most serious to the most trivial. Moreover, juvenile-court statistics include not only cases in which children are adjudged to be delinquent but all cases brought before a court in which delinquency is alleged.

Because of their limitations, juvenile-court statistics alone do not provide a reliable index of delinquency in each community. These statistics are apt to be particularly misleading if used to make comparisons between one community and another respecting the extent of delinquency.

On the back cover of this supplement are described revisions of the Children's Bureau reporting program that it is hoped will improve these juvenile-court statistics.

Table 4.—Juvenile-delinquency cases, 1945: Sources of reference to court, in boys' and in girls' cases disposed of by 374 courts

Source of reference to court	Juvenile-delinquency cases					
	Number			Percent		
	Total	Boys	Girls	Total	Boys	Girls
Total cases	122,851	101,240	21,611			
Source of reference reported	96,262	79,534	16,728	100	100	100
Police	68,682	60,049	8,633	71	75	52
School department	6,976	5,027	1,949	7	6	12
Probation officer	2,971	2,224	750	3	3	4
Other court	1,760	1,343	417	2	2	1
Social agency	1,362	752	610	1	1	5
Parents or relatives	5,751	2,951	2,800	6	4	17
Other individual	7,777	6,304	1,473	8	8	7
Other source	1,220	884	336	1	1	2
Source of reference not reported	26,589	21,706	4,883			

Table 5.—Juvenile-delinquency cases, 1945: Places of detention care of boys and of girls, in cases disposed of by 374 courts

Place of detention care	Juvenile-delinquency cases					
	Number			Percent		
	Total	Boys	Girls	Total	Boys	Girls
Total cases	122,851	101,240	21,611			
Detention care reported	76,002	62,353	13,649	100	100	100
No detention care over night	43,100	36,824	6,276	57	59	4 ¹
Detention care over night or longer	32,902	25,529	7,373	43	41	54
Boarding home	431	292	139	(1)	1	(1)
Detention home	22,659	16,948	5,711	30	27	42
Other institution	701	503	198	1	1	2
Jail or police station	8,733	7,967	766	12	12	9
Other place of care	156	75	81	(1)	(1)	1
Place of care not reported	261	204	57	(1)	(1)	(1)
Detention care not reported	46,849	38,887	7,962			

¹ Less than 0.5 percent.

² Includes cases of children cared for part of the time in detention homes and part of the time elsewhere but excludes cases of children also cared for in jails or police stations.

³ Includes cases of children cared for part of the time in jails or police stations and part of the time elsewhere.

⁴ Includes cases of children cared for in more than one place but in places other than detention homes, jails, or police stations.

Table 6.—Juvenile-delinquency cases, 1945: Dispositions of boys' and of girls' cases, disposed of by 374 courts

Disposition of case	Juvenile-delinquency cases					
	Number			Percent		
	Total	Boys	Girls	Total	Boys	Girls
Total cases	122,851	101,240	21,611			
Disposition reported	114,887	95,927	18,960	100	100	100
Case dismissed, adjusted, or held open without further action	19,040	12,184	6,856	43	45	35
Child supervised by probation officer	34,981	28,820	6,162	30	30	31
Child committed or referred to an institution	10,101	7,748	2,353	9	8	12
State institution for delinquent children	5,759	1,640	4,119	5	5	6
Other institution for delinquent children	3,157	2,346	811	3	2	4
Penal institution	222	205	17	(1)	(1)	(1)
Other institution	553	556	377	1	1	2
Child committed or referred to an agency or individual	5,400	3,546	1,854	5	4	9
Public department	1,751	1,183	568	2	1	3
Other agency or individual	3,649	2,363	1,286	3	3	6
Other disposition of case	15,365	11,720	3,645	13	13	13
Disposition not reported	7,964	6,313	1,651			

¹ Less than 0.5 percent.

Improvement of Juvenile-Court Statistics

To increase the significance and effective use of juvenile-court statistics and to achieve greater efficiency and economy in their collection and tabulation, the U. S. Children's Bureau initiated on January 1, 1946, a revision of its juvenile-court statistical reporting program. Under the revised reporting plan, the Children's Bureau discontinued the direct collection of statistical reports from individual courts and will tabulate only summary reports received from State agencies concerned with juvenile-court or probation work (e. g., departments of welfare, State-wide juvenile courts, departments of probation and correction). These summary reports will be based on individual court reports to the State agencies.

State-agency collection of juvenile-court statistics will extend materially the geographic coverage of the series to include more urban and rural courts in all sections of the United States. This arrangement will be advantageous also to individual courts because they will be able to seek advice and consultation on statistical reporting procedures and related matters from agencies in their own States.

The revised reports will include (1) a count and analysis of all children's cases—delinquency, dependency and neglect, and special proceedings—disposed of officially (formally) and unofficially (informally) during the calendar year, and (2) an unduplicated count of the number of different children involved in all children's cases disposed of during the calendar year. Reports of this nature will present a better picture of the work of juvenile courts and will be extremely useful in State and local planning of programs of preventive and treatment services for children.

Another approach to the improvement of statistics on delinquency is described in a recently released report on an experimental registration of juvenile delinquency undertaken in the District of Columbia by the U. S. Children's Bureau in cooperation with the Washington Council of Social Agencies.¹ The experiment employed

the technique of central registration of children whose behavior was reported as delinquent by each of the six official agencies in the city concerned with juvenile behavior.

The results of this study indicated that a large number of children alleged to be delinquent were not known to the juvenile court during the registration year, having been dealt with by the police or by other agencies without referral to court. The study also indicated that, because of duplication in the statistics for any two agencies, central registration may be the only feasible method for completely unduplicating on a community-wide basis the count of children alleged to be delinquent. Central registration may be a step toward improved measurement of juvenile delinquency and may hold possibilities as a tool for better community planning of services for children and youth. However, the procedures involved need to be tested in additional areas to ascertain the effect of differing community provisions and interagency relations before general conclusions and recommendations for its use can be made.

¹ *A Community Experiment in the Measurement of Juvenile Delinquency*, by Edward E. Schwartz. National Probation Association Yearbook, 1945 (New York: 1946). Pp. 157-184. A limited number of reprints of this article are available from the U. S. Children's Bureau.

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The reports in this supplement were prepared by I. Richard Perlman, Social Statistics Section, Division of Statistical Research, U. S. Children's Bureau.

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